the Canadian Nurse

VOLUME 57 • NUMBER 10

MONTREAL

OCTOBER, 1961

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THE CANADIAN NURSE

VOLUME 57 **NUMBER 10**

OCTOBER 1961

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Between Ourselves

Early last summer, two members of the *Journal's* editorial staff had the privilege of attending many sessions of the World Congress of Psychiatry that was held in Montreal. Their report, in general terms, of what they heard and learned opens this issue. With several different papers being given at the same time, in different salons, it was necessary, first, to study the program very carefully and decide which papers would be most helpful to hear. Papers were presented in many different languages but thanks to the superb simultaneous translation and the miniature transistor radios, no language problem was experienced.

The session devoted to psychiatric nursing was, of course, of greatest interest. We are fortunate in having some of the papers, presented by outstanding nurses, for publication in this issue. With these, we have combined some papers by Canadian contributors, two of which were given at a special conference on mental health held in Halifax last year under the auspices of the School of Nursing, Dalhousie University.

* * *

We had a discussion recently among some of the staff in the *Journal* office respecting the difficulty in defining what we actually mean by the word "health." You are as familiar as we are with the definition provided by the World Health Organization. You would agree that health is not merely the absence of disease, but what is it? Is it a state of physical and mental perfection? Surely not, for how could any of us ever hope to reach perfection? Who of us is 100 per cent healthy at this precise moment? Could dental cavities, for instance, be classified as an evidence of disease? Do your spectacles give you perfect vision? Do your arches ever hurt? Have you the odd corn or two? What *is* physical health?

Even more difficult to define precisely is the term "mental health." What are the things that we recognize as indicating mental illness? Mostly, they are signs of too strong and too prolonged emotional reactions. Depression, suspiciousness, jealousy, anger, are some of these signs, yet how much jealousy might you observe before it would be regarded as being mentally unhealthy? What qualities do we look for in an individual's behavior or his personality functioning that would lead us to say that, to a reasonable degree, he is mentally healthy?

Dr. R. O. Jones, a Halifax psychiatrist, thinks the following things are important as guides:

1. A reasonable degree of knowledge of one's self — a person needs to have a view of what sort of make-up he has and what are the assets and liabilities of his personality structure. A common problem is the person who consistently undervalues himself, has no self-confidence, constantly devalues the abilities he has.

2. Recognizing our liabilities and assets, we have to learn to live with ourselves as we are. Our attitude toward ourselves is developed by the image of us given to us by people who are important in our lives. A most serious threat to mental health is the method that seriously interferes with a child's acceptance of himself as a worthwhile person.

3. This self-knowledge and acceptance will lead to the establishment of certain patterns of behavior that we look for as signs of developing emotional maturity. We recognize certain primitive drives, such as aggressiveness, and strive to set up appropriate controls. Some sort of balance must be built up between over-aggressiveness and abject submission, between independence and dependence.

4. With all of this knowledge of self, it is a mark of good mental health to use the assets that we have in as productive a way as possible. The individual who learns to face his problems, to accept responsibility, to learn from his failures, will pass the acid test of good mental health — the ability to cope with the world as it is; the ability to form stable and satisfying relationships with other people.

The world is changing. We contemplate stupified, the fascinating rhythm of mutations and inventions, and we consider, without understanding, this era in which we are no longer the sons, and which does not give us the time to be its contemporaries.

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Bibliography: 1. Lamphier, T.A.: Am. Surgeon *26*:350-354 (May) 1960. 2. Wager, H.P., and Melosh, W.D.: West. J. Surg. *67*:280-282 (Sept.-Oct.) 1959. 3. Turow, D.D.: Clin. Med. *6*:791-796 (May) 1959. 4. Frazer, J.W.; Flowe, B.H., and Anlyan W.G.: J.A.M.A. *169*:1047-1051 (March 7) 1959. 5. Stone, M.L.; Schlussel, S.; Silbermann, E., and Mersheimer, W.: Am. J. Surg. 97:191-194 (February) 1959. 6. Haycock, C.E.; Davis, W.A., and Morton, T.V.: Am. J. Surg. *97*:75-78 (January) 1959. 7. Fabi, M.: Gazz. Med. Ital. *166*:159-161 (April) 1957.

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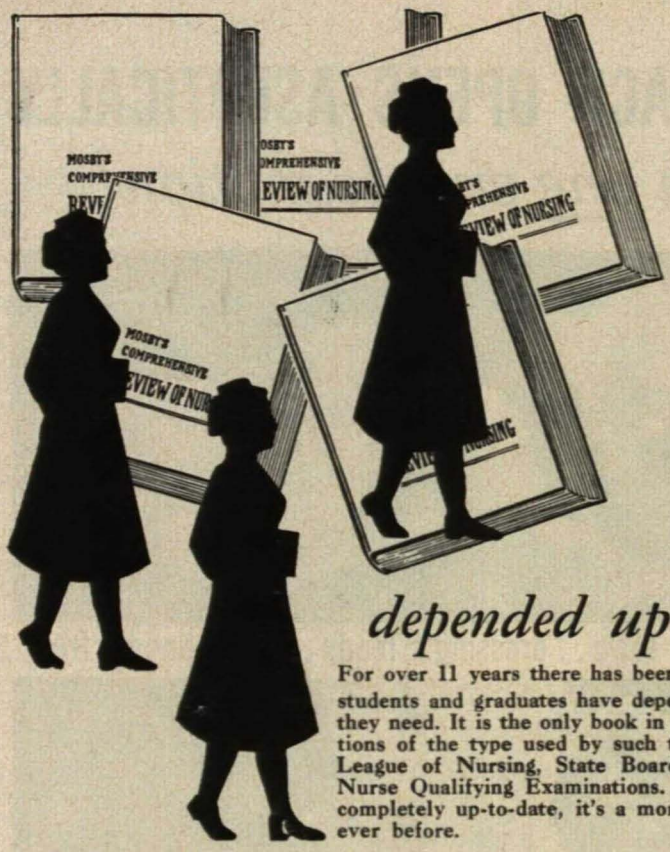

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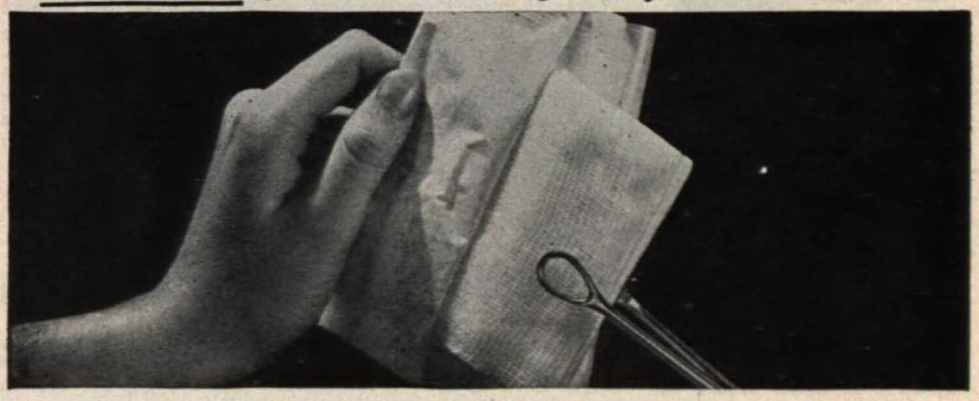

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1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

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†Beck, J. W.; Saavedra, D.; Antell, G. J., & Tejeiro, B.: *Am. J. Trop. Med.* **8**:349, 1959.

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Random Comments

Dear Editor:

Please note my change of name and address. I wish to continue receiving your informative and useful magazine to keep me up-to-date on the latest news and ideas even though I have stopped working since my marriage.

DONNA E. GAUDON, British Columbia

Dear Editor:

The March, 1961 issue of *The Canadian Nurse* is devoted to a discussion of ophthalmological conditions. I think it is one of the most complete discussions of eye conditions which I have seen in a periodical. I particularly liked the sections on nursing care.

I intend to use it as an aid in teaching professional student nurses.

ANITA L. THORNE, Pittsburgh, Penna.

Dear Editor:

Thank you very much for publishing my article about "The Public Health Nurse in Research" in your July issue. I was particularly pleased with the editing and the titles of the various divisions.

It was very kind of you, and I appreciate it. I have received some very nice comments.

EDNA LA FLAIR, Ontario

Dear Editor:

May I say how much I enjoy your *Journal.* The articles are very interesting and thought-provoking.

MARGARET GREGORY, British Columbia

Dear Editor:

After reading my *Journals* this last year, I have been sending them to the director of nursing of Passavant Hospital, Chicago. I am enclosing her note of thanks.

I feel that our *Journal* is one of the very finest of nursing journals and I have enjoyed it more each year. Last year and this year so far, I have found especially interesting.

I wonder if it is known that to get Illinois registration a nurse is required to take out her first citizenship papers. I think our nurses in Canada ought to realize this as many hospitals in Illinois advertise in *The Canadian Nurse.*

M. LUCILE STONEHAM, Chicago, Ill.

¶*The following letter was enclosed.* ed.

Dear Mrs. Stoneham:

Again, thank you for the copy of *The*

Canadian Nurse. Your generosity is enabling us to introduce this fine journal into our library. It will no doubt be of such use that we will need more than one subscription. Thank you for this introduction.

MIRIAM D. RAND

Dear Editor:

I would like to congratulate you on the very fine journal, *The Canadian Nurse.* Articles such as you publish are of real value. Keep up the good work!

SISTER HELEN GOUIN, Quebec

Dear Editor:

Our copy of the May issue of *The Canadian Nurse* has been taken from the library without benefit of check-out. We have hoped every day that it would be returned but it has not been and we do not dare to wait longer to re-order lest it be out of print. Will you please send us another copy?

The large class of nurses doing post-graduate work here this summer has certainly been using *The Canadian Nurse* a great deal. We are very happy that it is so useful, but do deplore its being so popular as to walk out without a by-your-leave.

MOLLIE SITTNER, Librarian,
College of Medical Evangelists,
Los Angeles, California.

Dear Editor:

I must confess that I haven't always read every article contained in *The Canadian Nurse.* However, I have thoroughly enjoyed every page of my re-acquaintance with the last two editions and will continue to do so.

Thank you for your combined efforts in giving Canadian nurses a magazine we can be proud of.

Best wishes in all your future ventures.

MARGERY RUTHERFORD, Nova Scotia

Dear Editor:

I have recently read an article in the August 1961 issue of *The Canadian Nurse,* entitled: "Emotional Aspects of Physical Handicap," by Dr. A. T. Jousse, of Toronto.

As a social worker this article interested me very much, and I do wish that it could be made available to our staff. I work in the Children's Aid Society, and though we are not specifically medical social workers I feel that Dr. Jousse's article would be eminently worth studying by those of us who work with families and children.

Is it possible that reprints of this article might be made available? This is an expensive undertaking, I realize. Failing this, may

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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I perhaps obtain a copy of this August issue, at least? I would like us to have it in our agency library.

My daughter, who is a R.N., has recently married, and may I say that I shall miss my access to *The Canadian Nurse*, as I have read it with considerable interest during the time it has been coming to her here.

MARY R. HANCOCK, Ontario

¶We are sorry reprints are not available, but we do have extra copies of the August issue on hand. Ed.

Dear Editor:

By your glowing account of the International Council of Nurses Convention held in Melbourne, Australia, I am sure every Canadian nurse will feel she was there in person and will greatly benefit in what you have recorded. The descriptive highlights bring to our attention very vividly the international nursing front, and contribute to a closer unity with our member countries. Your fine efforts are appreciated.

I can only express the highest praise for the *Journal*, climbing to such elevated standards. The surprises too! What is coming next? The color scheme, the main features listed on the front cover and the proposed multi-language chart! The articles are most informative and truly keep nurses abreast of modern thinking, not only technically but philosophically.

ELLA M. ROULSTON, Ontario

Dear Editor:

While sending you my change of address, I would like to take the opportunity to say that I look forward eagerly to each issue, especially now that I am not working. I am even re-reading some of the articles in my old copies! *The Canadian Nurse* is certainly a magazine that is an honor to our profession.

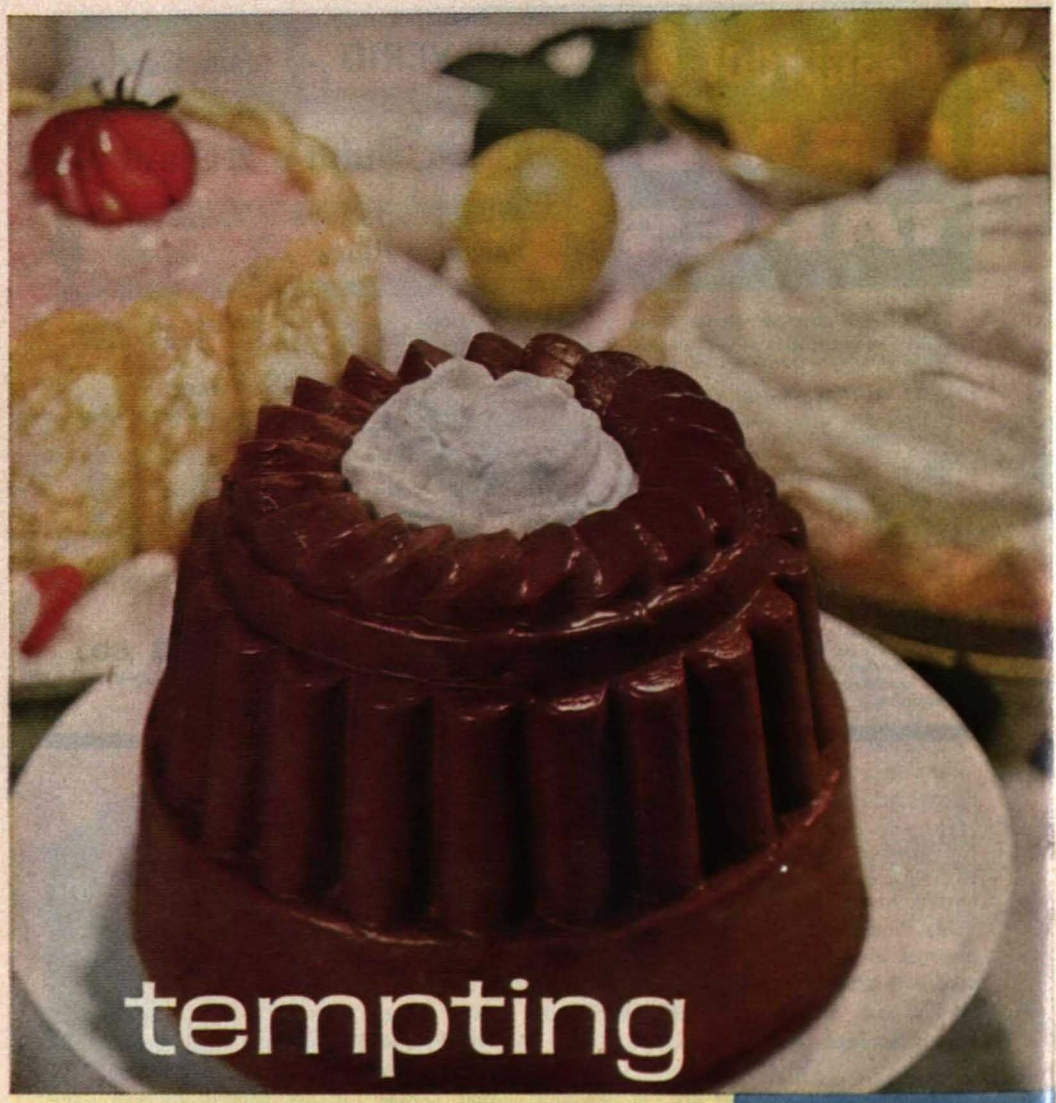
PATRICIA L. NEASE, Alberta

Dear Editor:

I am greatly interested in the filler item on Alconox published in *The Canadian Nurse* (July). I would appreciate information regarding where it may be purchased.

RUBY TOWNSEND, Alberta

¶In reply to this and other letters, listed below are the locations of the offices of the Canadian Laboratory Supply, the distributor for Alconox in Canada: 1449 Hornby St., Vancouver; 8540 - 109th St., Edmonton; 535 Marjorie St., Winnipeg; 80 Jutland Rd., Toronto; 8655 Delmeade Rd., Montreal. Ed.



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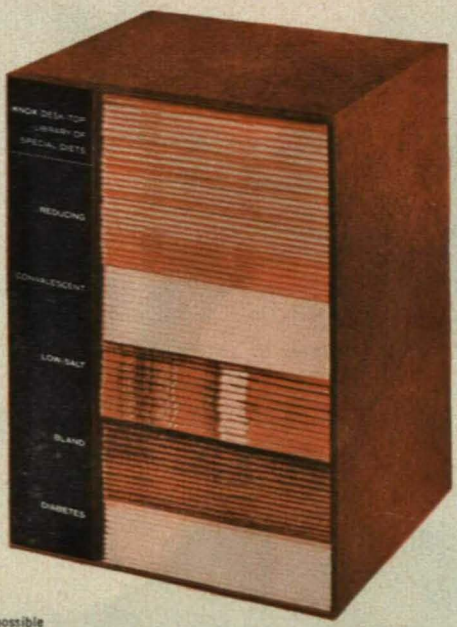
▲Food Exchange diets are easily individualized for one of three caloric levels and one of four sodium levels.

▲Shows how variety is possible for diabetic, eliminates calorie counting, promotes accurate adjustment of caloric intake.

◀Presents basic facts ulcer patients need to know about bland foods, frequent feedings and high protein intake.



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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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the 'teens—a time of transition

No longer a child, not yet a woman—surely the period of early female adolescence when your expert knowledge will be helpful. A word of advice to the youngster of menarche age may quiet her apprehensions and prepare her to accept all the important transitions of the female cycle. When your advice includes the use of Tampax—the modern tampon method of protection—you are offering the 'teen-age girl, in addition, the reassurance of safe, complete, discreet menstrual hygiene.

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PSYCHIATRY Has Something to Say

ON SUNDAY, JUNE 3, 1961 AT 4:00 P.M., representatives of the press, radio, television and a variety of professional and lay periodicals gathered in a salon of the Queen Elizabeth Hotel in Montreal. The occasion was the first press conference of the Third World Congress of Psychiatry. During the next hour, the guests were introduced to several world-famous psychiatrists who had been responsible for organizing this Congress. This meeting was only one of many ways in which the organizers sought to foster good public relations and facilitate news coverage of the events that were to follow during the next six days.

The hotel was alive with activity as more than 3000 delegates, representing 64 nations, registered. Many wives and children accompanied the psychiatrists to Canada and special programs were arranged for them throughout the week.

The opening ceremonies were led off by Dr. EWEN CAMERON, chairman of the Canadian Organizing Committee, and director of the Allan Memorial Institute of Montreal.

Men and women have come to this Congress from hospitals and clinics, from universities and research laboratories in almost every country of the world.

These are times that spur the spirit. Everywhere, men move forward on their great adventures — to the understanding of matter — to the opening up of space. Nowhere does enterprise demand more — nowhere does it give more promise — than in the understanding of man.

For man's mind goes out to the conquest of the stars. His mind is in the unravelling of the atom, and it is his mind, no less, which may destroy mankind. These are the days and ours are the occasions that summon up determination, fire the imagination and drive us forward in this greatest of endeavors.

The highlight of Monday's sessions was the academic lecture delivered by Professor JEAN PIAGET, psychologist, of Geneva, Switzerland.

The ego is made up on one side of connective structures, on the other side, of effective energy. Development is characterized by successive levels of integration. On the contrary, pathological states characterize disintegrations according to the same hier-

archial levels but the opposite way around. If integration shows stages one, two, three, etc., distintegration will occur in the order three, two, one. The application of these principles has been renewed by psychoanalysis on the affective level.

Psychoanalysis has shown that the affective life of an adult is the result of a series of transformations of successive levels and these go back to childhood. The child explains the adult and his developmental mechanisms explain the disintegrations.

The cognitive functions of the child also seem to show that the child explains the adult on the cognitive or intellectual level as well. All knowledge consists in transforming objects and attaining the laws of transformation.

Integration of the transformation structures takes place in different stages. First, the sensory-motor stage, since sensory-motor intelligence exists before language. At birth, the baby relates everything to himself.

After the sensory-motor level, as early as the age of two, is the apparition of symbolic functioning. The child begins to talk, to represent himself, to play symbolically, to imagine, etc., and representation and thought appear. The operations will not appear immediately.

During the period from two to seven or eight there is a pre-operative period where the child thinks, but does so mainly in a figurative way without attaining the operations and transformations systems.

Starting from seven to eight years of age, a system of transformation appears which could be called the first operation of intelligence — a system of interiorized action. From this age there are a series of operating structures which becomes elaborate classifications, series, construction of numerical operations, spatial operations.

Finally, only towards 11 or 12 years do the operations of adult logic appear — what logicians call logic propositional to the ability of reasoning on hypotheses and not only on concrete objects. The period finds its equilibrium towards 14 or 15 years of age.

Researchers are presently trying to determine whether one also finds this succession of stages in the opposite way in pathological conditions.

Trends in Mental Health Services

"A great change is evident in the attitude of the general public and of the medical profession, including psychiatrists, toward mental disorder and its treatment." This sentence introduced a paper given by Dr. WALTER S. MACLAY on trends in the British Mental Health Service. He said that this change was due to a variety of factors:

1. The obvious effectiveness of modern methods of treatment in spite of the fact that many are still largely empirical. These are: a) physical methods, such as E.C.T., b) drugs which can stimulate or tranquillize, and c) psychological methods such as individual and group treatment.

2. An increased recognition of the importance of social factors, interpersonal relationships and rehabilitation, well illustrated by the open hospital and the therapeutic community.

3. Loss of fear of mental disorder and greater toleration of it by the public. The whole philosophy of the new Mental Health Act (in Britain), is that care and treatment for the mentally disordered will normally be obtained voluntarily and informally in the same way that it is obtained for other medical and surgical conditions. In 1959, only 12 per cent of admissions to mental hospitals were compulsory; just over 15 per cent of admissions to mental deficiency hospitals were compulsory.

4. Early treatment without hospitalization has necessitated a great increase in the community and clinic services. From 1949 to 1959 there was a 54 per cent increase in first attendances at outpatient departments. The attendance of children at child guidance clinics has increased 433 per cent in the same period. There are now more than 40 day-hospitals in existence. These figures do not indicate, however, an increase of mental disorder. They do illustrate an acceptance of the efficiency of early treatment and necessarily affect the number of beds needed.

5. The acceptance of psychiatry in the general stream of medicine is one of the most important trends. It will not only benefit psychiatry but will also enrich the whole field of medicine in a way which can quickly lead to a revolution in the practice of medicine.

These factors have also influenced the various fields of activity of the Mental Health Services.

1. In 1959, the Ministry of Health took over the administration of the Mental Health Service, using the same medical and lay officers as are used for the other health services, and the help of a small number of

doctors who are expert in the various fields of psychiatry.

2. The Mental Health Act defines under the general title of "Mental Disorder" four categories of patients, all of whom are affected by the new trends:

a) *The mentally ill:* If present trends continue for ten years, less than 50 per cent of the beds now in use for the treatment of mental illness, will be needed — a reduction from the present figure of 3.4 beds per 1,000 of the population to 1.8 beds.

b) and c) *The subnormal and severely subnormal:* The need for beds will not disappear but new hospitals will be smaller with opportunity for better classification, and treatment, appropriate to the needs of the patient.

d) *Psychopaths:* Those requiring maximum security will go to special hospitals provided by the minister; observation and diagnostic centres will be set up with facilities for research and training staff.

3. Community services — The pattern of hospital services makes no sense unless it is linked with a whole new development in the community services for the old, the sick, the mentally ill and the mentally subnormal. What is needed is a complete range of services graduated to cater for the complete independence of full mental and physical health, and the almost complete dependence of the old or subnormal when the need for care and attention is little short of that which only a hospital can provide.

4. The increasing recognition by the general practitioner of the importance of psychiatry in general practice and acceptance of the obligations involved, are helping to restore him to his proper place as leader in the prevention and treatment of illness. But much remains to be done, especially in the medical schools.

The acceptance of psychiatry as part of medicine is accelerating the growing realization in the medical profession and especially among general practitioners of the vital importance of psychological and social factors in the whole realm of their work.

Forensic Psychiatry

This topic created so much interest and response that two general program sessions were arranged, as well as sub-sections on two afternoons. It was not possible to attend all of these sessions, nor to include the substance of all the papers that were given. However, highlights of some of the papers follow.

In introducing a panel of speakers, Dr. M. REMY of Switzerland noted the present limits of criminal psychopathology. The psychiatrist often sees only the most resistant, and does not see those who are in the early stages who can really be helped.

Dr. BRUNO CORMIER of Montreal discussed the topic "Divergent Views Between Law and Psychiatry on Problems of Sentencing."

In medicine, we are accustomed to the idea that illness is part of life, and until mankind has achieved a state of permanent good health the occurrence of illness must be considered as normal. A man who suffers from a disease is felt to be in a pathological state requiring treatment.

Criminality, like illness, can be regarded as a normal social phenomenon. Criminal behavior can be regarded as a symptom of a pathological relationship between an individual and society. Not unlike its medical counterpart, it requires diagnosis, prognosis and treatment, the latter usually known as rehabilitation.

The judicial process of arrest, trial and sentence, can have profound psychological effects, not only on the offender but also on all those concerned with him. These psychological stresses are well-recognized in judicial proceedings in juvenile courts. If the individualization of the judicial process is a contemporary concept that all modern justice aims to achieve, then it must take into consideration the psychology of the adult in all phases of the administration of justice.

Four principles must be agreed upon before law and psychiatry can achieve the goal of individualization of sentencing:

1. *Equality of the individual before the law:* Men are unequal — in intelligence, in physical and mental health, in social rank and role, in their capacity to take responsibility, and in many other factors. The apparent paradox of a man being equal before the law and unequal in fact can be reconciled if jurists and psychiatrists agree that men are equal when it is a question of *confirming innocence or guilt.* After the verdict has been reached, however, the jurists must then acknowledge the inequality of man.

The role of the psychiatrist is to examine the guilty man, assess his personality — his defects, his assets — and formulate a clinical

impression not only in function of his offense, but in function of his total life. He can then convey to the judge, in a pre-sentence report, his impressions and suggestions.

2. *Retribution:* Retribution is a human sentiment, an expression of the instincts of aggression in so far as it is synonymous with retaliation and revenge. It is one of the earliest and most primitive forms of justice. Modern justice must recognize that, in spite of the controls acquired by civilized man over his instincts of aggression, revenge may always manifest itself in disguised ways. A sentence that is too severe is usually the result of feelings of revenge.

3. *Deterrence:* Punishment as a social deterrent is founded on the belief that if an individual offender is given an exemplary sentence, the severity of the punishment will deter others from committing similar offences. This belief has never been proven scientifically and should not serve as one of the bases of modern penology. Exemplary sentences pose a moral question to which the law must find an answer: Has anyone the right to utilize an individual as an example for the theoretical benefit of society?

4. *Crime as a symptom:* We have already defined crime as a social illness. In medicine we are accustomed to view a symptom as the manifestation of a pathological state. We are also well acquainted with the fact that a severe symptom may correspond to an easily-curable disease, while a relatively minor symptom may indicate a serious illness. Similarly, in forensic psychiatry, the commitment of severe offences may reveal relatively minor pathology, while minor offences may indicate a severely pathological character. It follows that the commitment of one or many offences should be regarded as symptomatic acts in a state of social maladjustment. As in medicine, the criminal act must be a point of departure for a diagnosis, a prognosis, and treatment.

In conclusion, the right to receive an individualized sentence in modern society, must be an unalienable right of a guilty person.

Dr. MELITTA SCHMIDEBERG, director of Clinical Services of the Association for Psychiatric Treatment of Offenders, New York, chose as her topic "The Neurotic Offence — Does it Exist?"

There is a need to clarify the concept of the "neurotic offender," whose unconscious guilt and desire for punishment make him break the law. Such a clarification has tremendous implications, not only for the psychiatric treatment of the offender but for legal and correctional practices. There are many issues involved:

1. We cannot discuss the "neurotic offender" without discussing the psychopath. Psychopathy is a legitimate diagnosis. Under certain circumstances and using a specific approach, many affected persons are treatable and capable of learning. Thus, treatability is no argument against the diagnosis of psychopathy, no proof that the offence was committed because of a neurotic wish for punishment.

2. The word neurotic is used too vaguely. *Ordinary* habits of cleanliness or tidiness, the presence of emotional conflicts, and even painful emotions are regarded as proof.

3. The fact that a patient is arrested is no proof that he wanted to be. Allowing for efficiency of law enforcement it is bound to happen.

4. Prison represents not just punishment — it provides a roof, security and even companionship.

5. In trying to motivate patients for treatment, I have found that fear of punishment, if handled correctly, is one of the strongest motivating forces.

6. Neither psychopathy nor neurosis is a watertight entity. The former may include pseudo-neurotic reactions, especially under stress, while the neurotic may have impulsive (mildly psychopathic) reactions, sometimes due to stress, sometimes to temptation and loss of controls.

The aims of psychotherapy are to sensitize the offender to social pressures, to develop a normal attitude toward punishment and to teach him to foresee consequences. The aim is to adjust him to the legal framework, not to take the framework away.

Criminals do not have an overstrict conscience demanding punishment, but an insufficiently developed conscience and the hope to get away.

If a neurotic has a strong need for punishment, he can find many other ways of causing himself pain, but his conscience will prevent him from breaking the law in any serious manner. It is unfortunate that a theoretical confusion has arisen between the neurotic character and the antisocial personality or the psychopath, who are opposites and require different handling.

Dr. BURGER-PRINZ of Hamburg,

Germany noted particularly that penal laws must be further developed in their structure to increase the possibility to judge — to see the past history of the delinquent or criminal.

In modern society, our views are subject to constant change and the attitude of society is important. It is also difficult to convince society. Nothing is worse than a law which does not take these factors into account.

We must welcome the fact that in new penal law, pathology, its kind and stage, is not neglected. It takes into account a mixture of psychological and non-psychological measures.

Psychiatry and its pronouncements are valid enough to justify our statements on human beings and their nature. We cannot resort to only one method — we need other views on other levels, that is, sociological, biological and a knowledge of the bases of psychoses.

Two major proposals were made which would advance forensic psychiatry:

1. Broad cooperation with other disciplines,
2. an international body of forensic psychiatrists.

Child and Family Psychiatry

Dr. LAURETTE BENDER, director of the children's unit, Creedmoor State Hospital, and consultant for the New York State Department of Child Psychology, said that it is better for a very young child to have a bad mother than to have no mother at all. A child deprived of a mother and (or) father during the first two years of life, will have no concepts of the parental roles or even of his own role in life. It is important to have concepts and to have feelings, even if they are wrong. The latter can be corrected later.

To leave a baby in a hospital crib for the first six months of its life can be very dangerous and may even lead to death. This is why foster homes are so essential for orphans. The child should have the same mother relationship at least until he is of school age. Moving the child from one foster home to another can have harmful effects.

Comic books and television, in spite of westerns and detective stories, are *good* for children. This is so, not because the child gets some vicarious satisfaction or thrill from an "aggressive movie" but because he identifies with the person in the film or comic strip (e.g., Dick Tracy) who is solving a problem. He gets out of it what he wants and leaves the rest.

Evidence that mental illness in children may have been caused by events just before or at the time of birth, was presented by Dr. Bender. In a study of 300 children with mental illness, there was a history of difficulty during pregnancy or at birth in 66 per cent. The patents were classified roughly as childhood schizophrenia 50 per cent, brain damage 33 per cent, the rest behavioral disturbances.

Three major causes of childhood mental illness were: bleeding during pregnancy, toxemia, and premature birth. A great deal of significance is attributed to abnormalities in previous pregnancies.

Psychosomatic Medicine

Psychosomatic disorders can be defined as physiological disturbances that are the result of a variety of causes — psychological, social, cultural, etc. Since early times, man has been aware of the effect of these factors without paying too much attention to them. It was not until after the clinical observations of Freud that we began to associate the physical and the psychological — the relationship between attitudes, ideas, mores, social values and physiology.

An individual who displays well-being is one in whom there exists a harmony of functions between molecules, tissues, organs and systems. The biological processes are part of the ecology of living nature and are associated with a desire to be a personality in human society.

All physical or biological disorders should be considered psychosomatically, that is to say from the molecular level to the social level, according to the predisposition of the individual, the precipitation and the perpetration of the morbid state. Dr. ERIC WITTKOWER stated:

Psychosomatic medicine came into being as a reaction to a mechanistic, exclusively biologically-oriented era of medicine.

As a late result of the psychosomatic movement, it is likely that a new type of

general practitioner will emerge who, more than before, will pay attention to the personal problems of his patients, but grounded in scientific knowledge.

The present rapprochement between general practice and psychiatry is likely to continue and to grow. The present shift in emphasis in medicine in the direction of the psychological may result in "a major re-organization of the medical profession, probably establishing psychological medicine as a major branch coordinated with the whole of somatic medicine."

— TALCOTT PARSONS

Scientific Creativity

Registrants were privileged to attend, on Wednesday evening, an unprecedented discussion by three Nobel Prize winners. Congress planners had intended to admit the public to the lecture, but with a registration of over 3000 it was only possible to admit the registrants. The Sir Arthur Currie Gymnasium of McGill University was filled to capacity!

The speakers were introduced by Dr. DAVID L. THOMSON, Dean of Graduate Studies and Vice-Principal of McGill University:

LORD ADRIAN, Great Britain, awarded the Nobel Prize for medicine in 1932 together with Sir CHARLES SHERRINGTON, for discoveries of the formation of the neuron. Lord Adrian is Master of Trinity College, Cambridge, Vice-Chancellor of the University of Cambridge and one of the world's leading neuro-physiologists. Dr. ALBERT SZENT-GYORGYI formerly of Hungary, won the 1937 chemistry prize for his discoveries on biological combustion. Dr. Szent-Gyorgyi is now with the Research Institute of Muscle Research at Woods Hole, Massachusetts. Dr. LINUS PAULING, of the United States, was awarded the 1954 prize in chemistry for his study of the forces holding protein and other molecules together. Dr. Pauling is professor of chemistry at the California Institute of Technology and following his work on the forces binding proteins, he launched a study on molecular disturbances leading to mental deficiencies.

Lord Adrian spoke on the role of new tools and techniques in creativity in science. He made these points:

New ideas in science are induced by new discoveries and at the present time the most potent factor in promoting new discoveries has been the introduction of some new technique, some new tool which can be used for exploring natural phenomena.

The new discoveries will usually be made in the course of research with a definite plan, based on the theory or theories which we accept as reasonable. If the new results give fresh evidence for one or other of these we shall at least know how to go on. Sooner or later we can hope for the results which are unexpected and puzzling, because they do not seem to fit into any of the pictures we have made. These are the discoveries which will create the new outlook and make the decisive advances in science.

That brings us from the technical methods to the man who is using them, with a mind that is bold enough to neglect the fashionable pictures, and sufficiently in touch with contemporary thought to make the new picture which his colleagues can accept as a way out of their difficulties.

Technical developments have usually come because an ingenious scientist has realized some of the advantages they would bring and has noted an advance which might make them possible. The development has involved experiments and discoveries on its own account, but its effect has often extended to fields of research which were not the immediate concern of those who thought of it. The new instrument or new technique will appeal to some enterprising worker in a different field who needs better methods for his own research and before long he may be producing results which become the starting point for a fresh line of advance.

In these days, if science is to survive it must be creative in a wider sphere than that of the material basis of living organisms or living behavior. We are badly in need of the new discoveries and the new ideas which will help us to understand how the behavior of the individual organism can be regulated so that the community of individuals will survive, how, in fact, human societies can live contentedly with one another. Unless social science can be as creative as natural science, our new tools are not likely to be of much use to us.

The advance is bound to be more difficult in social than in physical science because the approach must be by way of observation rather than of experiment. We have to study a complex situation which is continually altering in directions beyond our control and the most trivial changes which we can impose on it may modify the whole pattern.

There are branches of medical science which share this difficulty, but we are slowly learning how to plan experiments so that

the result is not too much influenced by the fact that the experiment is taking place, by the attitude to it of the observers and the observed.

Is there anything that we can do now to encourage creative ideas in these very difficult but vitally important fields? We are training a great many able young scientists in the methods we understand and they are usually expected, as part of their training, to produce some finished piece of research which will admit them to the great company of Doctors of Philosophy. Those who are fortunate will profit by the advice of their directors and their discussions with one another and will not be forced into a common mould. They will learn from their mistakes and their successes will give them the confidence which is one of the most important ingredients in the scientific attack. But the content and methods and aims of research are changing so rapidly that we must be careful that the training we give does not produce too many timid scientists who can solve a minor problem and teach and criticize but have lost the drive to explore new regions.

Originality is certainly needed. Someone must break away from the pattern of thought set up by a great leader and respected too long by his loyal followers. But, we are all training our young men to distrust their elders and human nature will assist them to do so — so will the facts they may find if they look hard enough. Indeed, for creative science nowadays the capacity for taking pains is at least as important as the unconventional approach.

The urge to construct new tools is perhaps more primitive than the urge to gain enlightenment. But the ferment of ideas comes early and the scientists who will change our outlook by a new conception rather than a new tool may need encouragement from the start unless they have the sanguine temperament of a Rutherford or a Pavlov.

Good fortune certainly comes into scientific creativity: the photographic plate that is unaccountably fogged, the casual remark of a colleague that sets one thinking; one might add such events as the plague at Cambridge that sent Newton home to work in seclusion, or the particular conjunction of chromosomes that will breed a genius. When science does not advance, the fault may be in our stars and not so much in ourselves. At all events there are now so many of us on the look-out that the stars will be more than unusually unkind if someone has not the good fortune to see more light.

Dr. Szent-Gyorgyi opened his address with the comment that the Congress organizing committee must have found "scientific creativity" both important and accessible to analysis — an opinion with which he agreed wholeheartedly.

Human progress has been due in the past, to a great extent, to a relatively few creative minds and the same will be true, also, for the future. The fate of any nation will depend on the question of how far it will be able to produce creative brains. I am convinced that creative geniuses are always present in numbers, but are wasted. I base this opinion on the fact that they show no random distribution, but mostly appear in groups of three or four. This indicates that genius needs certain environmental factors for its development. I am also convinced that genius has nothing mysterious about it and can be found, once one has learned to decode its signs.

As chairman of the National Council of Education of Hungary, Dr. Szent-Gyorgyi intended to work out a system by which to find the outstanding intellects and to create the conditions necessary for their development. Unfortunately, political changes put an early end to his efforts and studies in this direction. As a result, he said that he could only speak of his own scientific research, because "it is the only one about which I have firsthand information."

In my present country, the USA, the development of outstanding creativity is greatly hampered by misplaced ideas about democracy, according to which we are all equals. Nature is not democratic and, as far as the intellect is concerned, does not make us all equals. Accordingly, there are good artists or scientists, and bad artists or scientists. The good ones make good art or science — the bad ones, poor art or science. Everything is being done to correct this undemocratic attitude of Nature and make us all equals, also in the domain of the intellect, lifting the retarded and knocking down the outstanding to the common level. If we had spent half as much money and thought on the outstanding, as we have on the retarded children, leadership would not be such a scarce commodity. Our tendency is to replace creativity by numbers, quality by quantity. Our reasoning is analogous to saying that if one woman can produce a child in nine months, nine women will produce it in one. Our reasoning does not hold true

even for this simplest form of creativity. There are pregnant ones and non-pregnant ones among us, and only those who are pregnant with ideas, will be creative. It is completely wrong to pretend that genius will always break his way. Genius, mostly, entails great sensitivity and nothing is easier than to discourage it.

If I look at myself objectively, the first thing I notice is that I find myself running, every morning at an early hour, very impatiently, to my laboratory. My work does not finish when I return in the afternoon. I go on thinking about my problems all the time, and my brain must continue to think about them even when I wake up, sometimes in the middle of the night. As far as I can remember, I have very rarely found the answer to any of my problems by conscious thinking. It acted only as a primer for my brain, which seemed to work much better, without my muddling, while I was asleep. Without such concentration and devotion nothing serious can be achieved, be it in art or in science.

Why do I do this? I am not a sort of human ant, and if I have any special gift it is an extraordinary capacity for loafing and relaxing. So why do I do this? This answer is simple: I have to. I am miserable if I can not. Somehow, problems get into my blood and they do not give me peace, they torture me. I have to get them out of my system and there is but one way — solving them. A problem solved is not a problem at all, it just disappears. An unsolved problem looms in one's mind as big as Goliath must have loomed to David. But once it is solved it just vanishes — it loses all interest. This is perhaps what drives us on and on and does not allow us to sit down and enjoy past achievement. "He who rests on his laurels wears them on the wrong place." All this is exciting but not pleasant. Creative occupation does not go without pangs of pain. All parturition seems to be painful.

What made me behave in this funny way, to run after problems I conjure up myself while most other people run after money and the like? I think I will never be able to answer this question. I am the fourth generation in a family of scientists, and have grown up in a very intellectual environment where only scientific or artistic achievement counted. As children we knew nothing about money or politics, but knew something of what was going on in art and science all over the world. Most of us lay down the standards of our evaluation at a very early age and cannot change them later. The shaping of our standards at an early age is therefore, a most important point for education.

Of course it would be entirely wrong to suppose that a corresponding family background will necessarily lead to the production of intellectual creativity. Neither of my two brothers took my line, nor is such a family background an absolute necessity for there are many examples of great scientists without it. Special gifts may lead man into scientific or artistic creation because everybody likes to do what he can do well, and the intellectual thirst, inculcated into me by education, can also be congenital and demand satisfaction.

How far secondary motives, such as vanity, the desire for recognition, the wish to be useful, or the longing for social or financial success are involved, is difficult to say. No doubt they play a role. Some of my work has turned out to be useful — contributed to health and happiness. There is no denying that I am pleased with this, but it had no serious part in my work. I have shunned lines that would put me into the limelight because of their usefulness. If any student comes to me and says he wants to be useful to mankind and go into research to alleviate human suffering, I invariably advise him to go, rather, into charity. Research wants *egotists*, who seek their own pleasure and satisfaction, but find it in solving the puzzles of Nature.

As to the role of material success, I know of only a very few significant researchers or artists who died rich. On the contrary, most of them died poor. I made only one discovery which would have enabled me to make money, but instead, I spent all my spare money on it. But I had a good and exciting time.

Neither intellect nor tradition in themselves, are sufficient for creativity — additional inclinations are needed. To be driven by the desire to find new knowledge is only part of the story. Being fairly ignorant of scientific literature, I could find more knowledge new to me in an hour's time spent in the library, than I could find at my workbench in a month or a year. It is not *truth* I am searching for, it is *new* truth. While travelling in France or England, you can see no end of interesting and exciting things, but there are born travellers, like Livingstone or Shackleton, who did not care for Paris or London but were excited only about a small white spot on the geographic map in the heart of Africa or at the Pole. There was nothing especially interesting there, but it was a white spot. A scientific researcher has to be attracted by these white spots on the

map of human knowledge, and if need be, be willing to give his life for filling them in.

I like to see things simple, a bit infantile, without much sophistication, wondering about the simple things. People often fail to see that something is a miracle if they see it often. To me, the greatest and most exciting miracles are what I see around me every day.

Finally, let us consider the qualitative value of scientific creativity. Ants have an enormous urge for creativity, building anthills which have no intrinsic value. The question is not *whether* we create, but *what* we create. This depends on the nature of the problem and posing a good problem is half the work. The bigger, the more fundamental the problem the better, but this has its limits and too big a problem is no good either. I like basic problems and could characterize my own research by saying that when I settled in Woods Hole and took up fishing I always used an enormous hook. I was convinced that I would catch nothing anyway, and I thought it much more exciting not to catch a big fish than not to catch a small one.

There are many ways to do research, so I would like to close by recalling correspondence which I had with a student who wanted to become a great researcher and asked me "What is the right way of doing research?" The only answer I could give him was that "the right way of doing research is doing it according to your own personality — if any."

Dr. Linus Pauling chose to speak on "The Genesis of Ideas," and like the previous speaker drew upon his own experience to illustrate his thoughts:

The genesis of ideas is the process of originating ideas.

Having ideas is a part of thinking. Some people have said that thinking is the process of solving problems. Professor John Cohen said that in Nature thinking is much broader than this in scope: that in much of our thinking we are groping to find out *what* needs to be done rather than *how* it needs to be done. Some of the most significant new ideas in science involve the recognition of new problems.

Many scientists have been interested in the question of the way in which scientific discoveries are made. A popular idea is that scientists apply their powerful intellects in the straightforward, logical induction of new general principles from known facts and the logical deduction of previously unrecognized conclusions from known principles. This method is, of course, sometimes used; but much advance in knowledge results from mental processes of another sort — in large part unconscious processes. Henri Poincaré in his essay on mathematical creation said that knowledge of mathematics and of the rules of logic is not enough to make a man a creative mathematician; he must also be gifted with an intuition that permits him to select from among the infinite number of combinations of mathematical entities already known, most of them absolutely without interest, those combinations that will lead to useful and interesting results.

From my own experience I have come to the conclusion that one way for me to have a new idea is to set my unconscious to work on a problem. I doubt that the unconscious can be directed to work on a problem. But the problem can be suggested to it, and if it is interested in it something may result.

The late C. G. Jung has said that art is a kind of innate drive that seizes a human being and makes him its instrument. A creative scientist is an artist — an artist whose ideas are in the field of science. W. W. Sawyer has described the behavior of school boys who are born mathematicians. They have mental venturesomeness: when one of them is told that no one has ever trisected an angle by means of ruler and compass alone, *he* attempts to carry out this operation; he has the *desire to explore* that marks the creative mathematician, and he may, throughout his life, have an unconscious that concerns itself, day after day (and also night after night) with the field of mathematics.

I once heard a commencement speaker say that there is no place in the world for the man who works just to satisfy his own curiosity; that instead everybody should work for the solution of problems that will benefit the world. He was an engineer, primarily interested in the application of knowledge to the solution of practical problems. But he had forgotten that the knowledge that he wished to apply must first be obtained, and that to obtain it is not easy. The knowledge that we have about the world, and that is applied for the benefit of mankind to the problems of technology and medicine, has in the main been obtained by men who were satisfying their curiosity about the nature of the world — by pure scientists and mathematicians.

Thomas Hunt Morgan once said that a little idea is enough to permit a scientist to get started. Even a simple experiment, when carried out, may suggest another one, and that another one until, as the result of a

succession of experiments and ideas, some significant discovery is made. As a geneticist, he might have said that ideas breed ideas.

My own experience, has suggested to me that it is possible to train the unconscious to help in the discovery of new ideas. I reached the conclusion some years ago that I had been making use of my unconscious in a well-defined way. I had developed the habit of thinking about certain scientific problems as I lay in bed, waiting to go to sleep. Sometimes I would think about the same problem for several nights in succession, while I was reading or making calculations about the problem during the day. Then I would stop working on the problem, and stop thinking about it in the period before going to sleep. Some weeks or months might go by, and then, suddenly, an idea that represented a solution to the problem or the germ of a solution would burst into my consciousness.

I think that after this training the subconscious examined many ideas that entered my mind, and rejected those that had no interest in relation to the problem. Finally, after tens or hundreds of thousands of ideas had been examined in this way and rejected, another idea came along that was recognized by the unconscious as having some significant relation to the problem, and this idea and its relation to the problem were brought into the consciousness.

As the world becomes more and more complex and the problems that remain to be solved become more and more difficult, it becomes necessary that we increase our efforts to solve them. A thorough study of the general problem of the genesis of ideas and the nature of creativity may well be of great value to the world.

It was a rare privilege to have attended a Congress such as this. The enthusiasm that was evident at every session could not help but impress me.

It seemed incredible that six or seven sessions, at which one to eight papers where presented, were going on concurrently each morning, afternoon and several evenings for six days. The opportunities for sharing ideas, successes and failures in research, and proposals for the future made this observer aware that psychiatry has something to say and psychiatry is saying it!

— PAMELA E. POOLE

In Memoriam

Clara Beall, who graduated from St. Michael's Hospital, Toronto in 1927, died suddenly on June 9, 1961.

* * *

Alice Beatrice (Spear) Beavan, a 1930 graduate of Royal Columbian Hospital, New Westminster, died during July 1961.

* * *

Agnes Burke who graduated in 1917 from Bath Main Hospital, Maine, died July 8, 1961, in Montreal after a lengthy illness. Her professional career had been devoted to private nursing.

* * *

Elizabeth Cahill, who graduated from St. Joseph's Hospital, Hamilton in 1917, died June 2, 1961 in Paris, Ont.

* * *

Isobel Boyes Code, who graduated from Toronto General Hospital in 1934, died on May 16, 1961.

* * *

Edna G. Darch, a graduate of Victoria Hospital, London, Ont. in 1926, died June 29, 1961.

Katharine Davidson, a 1907 graduate of the Royal Victoria Hospital, Montreal, died on July 17, 1961 after a short illness. She had practised her profession for almost 50 years.

* * *

Lucille (Marchand) Desjardins who graduated from Ste. Justine's Hospital, Montreal, died suddenly during July, 1961.

* * *

Mary (Edmonds) Edmonds, a graduate of the Royal Victoria Hospital, Montreal in 1911, died in England on June 5, 1961.

* * *

Laurette Forest, who graduated from Hôpital St. Eusèbe, Joliette, P.Q. in 1939, died on February 15, 1961. She was on the staff of the Société des Infirmières Visiteuses.

* * *

Laure-Annette Goyer, a 1938 graduate of Hôpital Notre Dame, Montreal, died June 28, 1961 after a long illness. She was on the staff of the hospital at the time of her death.

(Continued on page 953)

PSYCHIATRY TODAY

W. G. LAMBERD, M.D.

A summary of a talk given to the Manitoba Association of Registered Nurses.

THE TREMENDOUS PUBLIC interest in psychiatric problems and treatments makes it necessary that we examine carefully what psychiatry really has to offer at present. There is a danger that it is being oversold and if this is true there will inevitably be a swing of opinion in the opposite direction, with loss of interest and rejection of psychiatric concepts.

The extent of mental illness in this country is a matter of simple fact. More than half of the hospital beds in Canada are occupied by seriously ill mental patients. At least an equal number of people are suffering from some form of mental illness but are being treated outside of hospital. There must be hundreds of thousands of people with milder emotional disturbances who are receiving no treatment, either because of lack of facilities or because it has not been recognized that they need psychiatric treatment.

What does psychiatry have to offer to the seriously ill mental patient? The traditional physical treatments of psychiatry are still being used and are still effective in many cases. Electro shock and insulin coma treatment will probably not disappear completely despite the availability of many new drug treatments. There are now a large number of drugs known as tranquilizers. Their mode of action is not really known. However, we do know that when administered to people suffering from psychotic illnesses, such as schizophrenia, the psychotic manifestations are markedly reduced. This is probably not merely a matter of tranquilization; it is likely that the more potent of these drugs are fairly specific in removing such severe symptoms as hallucinations and delusions. In some cases they are replacing the older physical treatments. It seems likely that the number of admissions to mental hospitals may be reduced by their use in early cases of severe mental illness. Their action will undoubtedly shorten the stay in hospital for many patients and enable many others to remain at home as long as they continue the medication.

Unfortunately, these drugs are also being used rather indiscriminately for the treatment of fairly mild emotional disorders in which anxiety is a feature. It is doubtful whether anyone of them is more effective than the barbiturates in this treatment. They are certainly much more dangerous and have many more side-effects. There appears to be a universal seeking for tranquility. Is it necessary to reduce all anxiety with a pill? Is anxiety always a bad thing? It is often the spur that drives man to achievements that he would not reach if he remained in a state of tranquility. Again, if one removes anxiety there is often little reason why a patient should look into himself and his problems and make some effort to change himself. All psychotherapists realize that a moderate degree of anxiety is necessary for the attainment of any success in therapy. It is true that excessive anxiety tends to reduce efficiency and to produce disintegration of behavior patterns. The use of drugs to reduce this kind of anxiety is often justified but it would seem that the tranquilizing drugs are not very efficient for this purpose.

We also have available a new group of drugs which are known as "energizers" or "euphorizers." They appear to have the ability to remove depression, especially those we know as endogenous depressions. Their efficiency for that purpose approaches that of electro shock treatment and the medication is certainly more pleasant than E.S.T. However, most of these drugs have many unpleasant side-effects and some of them are downright dangerous. The indiscriminate use of drugs of this nature is completely unjustified. Mild psychoneurotic de-

Dr. Lamberd is clinical director at the Selkirk Hospital for Mental Diseases in Manitoba.

pressions often do not respond to the drugs any more than they do to E.S.T. There would seem to be no justification for administering a dangerous drug to a patient with a mild emotional disturbance, and most especially no justification for giving them to anyone who is in poor physical health in addition to the emotional disturbance. Probably even more efficient anti-depressant drugs will be produced in the near future. Perhaps one day we shall have a drug that will remove or relieve all kinds of depressions. What are the implications of this kind of medication? Just as a certain amount of anxiety can be considered as normal in some situations, it is also normal to feel sad and depressed under certain circumstances. It is necessary to grieve if you have suffered a loss. Such suffering may be unpleasant but the working through of grief is a much more efficient way of dealing with a realistic loss than taking a pill. It is not part of a psychiatrist's job to interfere with natural psychological processes such as grief and mourning or anxiety and guilt which are related to realistic problems. What then does psychiatry have to offer in the case of a mild emotional disturbance? The answer is usually, psychotherapy.

Almost any relationship between two or more people, in which some psychological changes occur which benefit one or more of them, could be called psychotherapy. One of the main problems is to utilize this kind of relationship therapy in a controlled way. Attempts are made to utilize relationships with the patient to benefit him psychologically by having him re-experience some of his old problems in the new relationship. Sometimes, this re-experiencing is carried out with little or no understanding on the part of the patient of what is occurring; sometimes, all aspects of the relationship are made clear to and examined carefully by the patient and therapist over a long period of time. Many types of psychoneurosis and many patients suffering from character disorders can be helped by psychotherapy. Here again, however, one must be careful not to oversell the product. It is probably not impossible to treat schizophrenia by psychotherapy but it is most difficult and beyond the ability of most psychiatrists. There are more economic and efficient ways of treating this disorder. In other conditions, such as involutional psychoses, it would be wrong to attempt to treat them purely by psychotherapy when it is possible to relieve the patient of his suffering very quickly by other means.

There is a tendency to feel that psychiatrists can treat all manner of gross behavioral disturbances. The public seems to feel that homosexuals and homosexual psychopaths should have treatment made available to them and that they should not be treated as criminals. Unfortunately, no one knows how to treat homosexual psychopaths and few people claim to have much success with overt homosexuals. There is little point in sending psychopaths to some kind of psychiatric institution while psychiatry has little to offer them. We should make strenuous attempts to find out more about these problems and to attempt various ways of treating them, but the public should not be given the impression that we know how to deal with these disorders.

Some of the gravest problems that a psychiatrist sees appear to have their roots in social ills rather than in individual psychological difficulties. Poverty, loneliness, deserted families and children who have been subjected to brutality and cruelty are problems that have their roots in the structure of society generally. The psychiatrist's role in social problems of these types has been poorly defined and many psychiatrists shrink from even approaching or making any comment on them. Psychotherapy has largely developed into the treatment of individuals in isolation and to some extent the psychiatrist has divorced himself from larger social problems. This may be due in part to the technical problems involved in treating individual patients with psychotherapy but it also may be due to personality problems of the psychiatrists generally.

Psychiatric education tends to stress the treatment of the individual and to under-emphasize the psychiatrist's role in the more general problems of mental health. There is little in psychiatry that is analagous to the position occupied by a medical officer of

health who is concerned with the total health of a community. This is illustrated by the problems of juvenile delinquency. There are many delinquents whose anti-social behavior can be laid at the door of their parents, even where the general social situation appears to be satisfactory. In other cases, delinquency is encouraged by the general attitudes of the whole society in which the child lives. Although there are individual psychological problems, the major emphasis should be on some attempt to alter the total social problems rather than attempting to treat each individual and his family.

Progress in psychiatry is influenced greatly by swings in public opinion. These have ranged from permissive attitudes and seeming acceptance of mentally ill persons to rigid authoritarian attitudes with rejection of the mentally ill. At the moment, we seem to be entering a permissive phase in which mental hospitals are opening their doors and extending out into the community in order to reach people who need help in an attempt to keep people from being institutionalized. I am not sure how long this trend is likely to last but we should take advantage of it while we can. The best method of gaining acceptance for mentally sick people is to prove to the public that we can help them. If we merely attempt to re-establish people in the community while they are still mentally ill, and especially if their behavior remains strange and frightening to people outside, we may precipitate a swing towards the rejection of this basically humane approach. We do have the means to restore many of the severely mentally sick to relative health to the point where they can be rehabilitated and accepted by the community. We should be careful, however, not to offer the public more than it can reasonably accept. There is a basic fear of mental illness in all of us and we will not be able to eradicate this by any high-pressured sales technique. Our main efforts should be directed initially towards showing people that we are capable of coping with mental illness, that it can be cured and that there is no reason for a hopeless, fearful attitude towards it at the present time.

For the Red Cross canvasser — in the lighter vein. The story is going the rounds about the old couple who lived in an isolated little shack at the top of a hill. The villagers in the valley kept a watchful eye on the wisp of smoke that came from the old couple's chimney. One day a heavy snow storm swept the area and after a week the villagers worried about the elderly couple. The local Red Cross decided to form a rescue crew. Eight men began digging their way up the hill and after many hours one man got through. After more shovelling he knocked on the door and called out, "I'm from the Red Cross." A quavering voice came from inside, "My husband gives at the office."

Changes in Psychiatric Nursing

MADELEINE LEININGER, M.S.N.

A reflection of the impact of sociocultural forces.

The Changing World

ONE OF THE MOST striking features of the world today is the prevalence of change in virtually all dimensions of human life. Changes in sociocultural values, beliefs and general behavior have been occurring within particular societies and among world societies for many years. Such changes are reflected in the conduct of people from one generation to another and are frequently acknowledged by such comments as, "People of this generation are different from my generation;" "I don't understand why people act the way they do today. We never behaved in that way."

Sociocultural changes are of particular interest and importance to professional people who are not only a part of such changes themselves, but who deal with others having multiple kinds of health problems that are greatly influenced by social changes. An awareness of the sociocultural forces that operate in a given society to bring about changes, can help the professional person to gain a deeper understanding of human behavior in health and illness. Anthropologists and other social scientists have frequently noted that human behavior and particular health problems are influenced by the social environment in which the individual lives.

The kinds of experiences that the individual has in his environment and the way he responds to them depends upon his culture. Fried and Lindemann, in a recent article have pointed to the importance of understanding sociocultural factors and of defining the conditions within which a person is likely to become a patient. They have indicated some of the ways in which a given behavior has different significance depending upon the context in which it arises. To them sociocultural factors are the "most general and regularized sets of determinants of these contexts."[1] Understanding the patient's community, his family, his work-associates, his cultural beliefs, values and dispositions is increasingly recognized as an essential requisite of knowledge for the modern health practitioner. The absence of such knowledge can limit the professional person's effectiveness with the patient and may determine to a large extent the patient's acceptance and participation in the treatment plan. Taking adequate account of social and cultural factors and the changes that they have undergone in a given society provides us with an important basis for understanding and treating individuals with various health problems.

Influential Factors

During the past decade there has been an exciting interplay between the social and cultural changes in our society and the changes in psychiatric nursing. Psychiatric nursing, as a part of our social system, has been influenced by and been a part of multiple sociocultural changes. Three major and closely related changes have occurred in the United States: The impact of the scientific attitude of inquiry; the heightened trend towards specialization; and the emphasis on continuous education. Each has produced some very positive and significant changes in psychiatric nursing.

This is an age of great scientific inquiry — an era of experimentation and specialization. Although psychiatric nursing cannot attest to worldwide achievements, yet progress has been quite evident. Advances have been made towards improving the quality of care to patients and in the promotion of psychiatric nursing as a specialized field of nursing practice

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Miss Leininger, who is associate professor of psychiatric nursing at the College of Nursing and Health, University of Cincinnati, gave this address at the nursing section of the Third World Congress of Psychiatry, Montreal, June 1961.

and as one that has an integral part in all aspects of nursing. The significant focus has been on a more scientific inquiry into and approach to nursing problems. The area of study has been psychiatric and non-psychiatric clinical nursing situations. Psychiatric nurses are currently involved in a critical examination of nurse-patient interactions as a means of identifying and describing the process and content of nursing practice. Obtaining scientific observations and descriptions of various nurse-patient interactions and clinical problems is a most important step in the further development of the psychiatric nursing field. Ultimately, its desired goal is to have an organized body of knowledge that provides the scientific basis for a theory of psychiatric nursing. As Nadel states:

> No science starts with random assembling and the collection of facts for their own sake. Science starts with problems, that is, with the question of why such and such facts occur in a given context or in a given conjunction. Science begins with the desire to understand, to see things in a systematic order. Description is the first step towards the realization of this desire.[2]

This scientific approach to psychiatric nursing has led to active questioning and testing of ideas with subsequent changes in the field. Since this is a more recent development, reports of such experimentations, innovations and general descriptive clinical accounts have not made their way as yet into the literature. Pressures in the past have often pulled psychiatric nurses away from focusing on research and scientific reports. For some nurses, it occurred because they did not fully realize the implications. Indeed, we know that nurses can readily spend their energies in "filling gaps" and meeting the multiple demands of other disciplines and so get caught in a whirl that never permits them to directly face professional problems that need scientific investigation. Other clinical team members will ultimately benefit from this full exploration of unrealized potentials in psychiatric nursing.

Even though an awareness of this goal is becoming more recognized among clinical team members, there remain those who are threatened by such advances and want to continue to perceive psychiatric nurses as the "doers" and handmaidens, and not as scientific thinkers, communicators, actors and creators of their own paths. The upgrading of nursing care to patients is contigent upon this beginning scientific approach that will blend the older valued humanitarian elements of psychiatric nursing with the newer elements.

Interaction

One of the major areas of emphasis has been the study and examination of the nurse-patient interaction process. A body of knowledge regarding this process is being developed as a means of helping student and graduate nurses to establish and maintain meaningful relationships with patients. Such knowledge helps the nurse to be aware of her important role with the patient, whether the contact is of a short or a long duration. It helps her realize that her contacts do influence his behavior and have an effect on the treatment goals. Three broad phases have been identified to provide a conceptual framework within which nursing functions and activities can be perceived and carried out: Initiating the relationship; continuing the relationship; and concluding the relationship. A series of events and anticipatory behavior between the patient and the nurse takes place during each phase.

Nursing care goals are formulated with consideration of the over-all treatment plans for the patient. Broad treatment objectives such as, supporting dependency needs; offering opportunities for feminine identification; limiting regressive tendencies; supporting the patient in decision-making; facilitating the expression of conscious hostility; setting limits on behavior that tends to increase anxiety or guilt are goals that require further refinement as they are implemented in relation to the immediate and long-term nursing care needs of the patient. The natural mothering qualities of warmth, compassion, support and acceptance, fundamental to all nursing care practices, are brought into harmony with other therapeutic measures and treatment aims.

Much thought is necessary as the nurse works with the patient in build-

ing feelings of trust; in providing comfort; in offering support, reassurance, companionship, respect and acceptance; in facilitating consistency in the management of the patient. Blending the physical and emotional components of care so the patient does not feel a fragmentation or compartmentalization in ministration to his needs or in interests towards him is an attribute much to be desired in the psychosomatic nursing approach. It is one of the highest medical and nursing skills. An effective relationship with the patient requires the nurse to use her scientific knowledge of human behavior. There is little room for stereotyped behavior and routines that do not consider the individual needs and problems of each patient. Thoughtful and purposeful goal-directed words and actions are a characteristic of therapeutic relationships. Furthermore, it is within the on-going process that purposeful action can take on meaning as the nurse examines and appraises the current needs and behavior of the patient and makes nursing judgments as she works through specific health problems in daily living situations.

Problem-solving

This type of approach, as a scientific and systematic way of thinking through and exploring problems, is a useful tool in ascertaining the nature of a patient's problem, his feelings, and needs. It helps to determine a more logical course of action and offers a scientific appraisal of nursing situations. Since it is an organized way of thinking, it assists the nurse in collecting and analyzing data; in examining what happened; and in making predictions about the course of her actions. The utilization of the steps in problem-solving is becoming an integral mode of nursing practice.

Verbal and Non-verbal Communication

The conscious examination and appraisal of verbal and non-verbal communication between nurse and patient is another important area that reflects a more scientific approach than previously. Efforts to help the nurse become sensitive to what she says and hears and to assist her in becoming aware of her own patterns of communication have become increasingly apparent. It has been an extremely valuable way of helping her to learn more about herself, her patients and other people. Personal expectations, distortions in verbal interchanges, recurrent verbal slips and non-verbal cues are carefully explored with the nurse through the use of media such as tape recorders, written interaction accounts, sociodramatic incidents and the reports of skilled observers in various nursing situations. Again, we find verbal interchanges are being directed toward more purposeful goal-directed actions. As Peplau states:

> Social chit-chat is replaced by responsible use of words which help to further personal development of the patient . . . Talking with patients becomes productive when the nurse decides to take responsibility for her part in verbal interchanges.[3]

An area of communication that is not receiving sufficient study concerns the multiple signs, gestures, tactile and body movements that occur so often in the nursing care of a patient. These are evident in all patients but especially those who are in a semi-conscious state or who are acutely disturbed. In those situations and a host of others, both the patient and the nurse use a large number of non-verbal signs that are taken for granted and have not been specifically isolated and studied for their meaning.

> A male patient, age 23 years, had spoken only a few audible words for a seven-year period prior to his hospitalization. Current and past history gave clues that the patient had long-standing and deeply hostile feelings toward his mother that he was unable to express. A graduate student had been working with this patient for approximately three hours each day. The first week he was very quiet, shy and passive. One day during the second week the patient grabbed the student's hand and twisted it very hard but withheld verbal comments. The student expressed her displeasure by saying, "That hurt a lot! I think we can help you find better ways to express your feelings."
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> A short time later, she casually suggested a game of ping pong during which he struck the ball vigorously. In subsequent encounters, he would occasionally

grab her hand and twist it, but the intensity and duration of the twist became much less. The student was aware of the patient's intense hostility toward his mother. This helped her to accept his impulsive ways of expressing his anger. The opportunity for this patient to use non-verbal interchanges in expressing his deep underlying feelings with an adult who represented a significant person to him, became a turning point in his recovery. A short time later the patient began to talk with the student.

Many other similar examples of non-verbal communication could be offered by nurses. The overt and subtle uses of the hand, face and body movements to express different kinds of feelings and the nurse's response to such expressions is truly a rich area for clinical nursing research.

With the impact of psychodynamic concepts of human behavior and the theoretical concepts of interpersonal relationships, a broader and deeper perspective in viewing the patient's behavior can be noted in psychiatric nursing. This wealth of very rich, dynamic and stimulating content is gradually extending its boundaries and reaching into other nursing areas. Content related to the importance of early life experiences, ego development, self-identity, and general concepts related to the dynamic process of growth and development throughout the life cycle have now become important areas in most undergraduate nursing curricula. Knowledge of cultural and social concepts of human behavior from the fields of anthropology and sociology have, in a very limited way, been scrutinized for their relevance and scientific use in psychiatric nursing.

The Supervisory Process

In helping student and graduate nurses to deepen their understanding of the patient's behavior and to gain some degree of insight into their own, the supervisory nursing process has emerged. Individual supervision as a method of teaching psychiatric nursing principles and concepts is under study by several psychiatric nursing educators. The thinking of Bregg,[4] Norris,[5] Peplau,[6] Fernandez,[7] and others offer pertinent concepts regarding the process, method, learning climate and teaching approach in helping students to learn and to develop useful interpersonal relationships with patients. Since the methods, techniques and purposes of individual and group nursing supervision both on the undergraduate and graduate level are currently under study, very diverse patterns and ideas about nursing supervision are likely to be found. As the term is used here, it refers to the guidance offered to the student by a competent nursing clinician during the student's direct work with a patient in a learning climate that:

> Facilitates her professional growth; deepens her understanding of the patient's behavior and his illness; helps her to explore some of her overt feelings and responses toward the patient; identifies and clarifies problems related to the nurse-patient relationship; encourages the student's thinking about developing effective ways of working with the patient; and fosters self-appraisal of nursing judgments and actions.

Regular conferences are held with the student. Her interaction notes are a tool for analyzing and appraising the student-patient interaction and for guiding subsequent nursing actions. Nursing supervision helps to provide continued professional development and assures a more therapeutically-directed relationship with the patient. It coordinates the student's efforts with those of the clinical team.

Group Nursing Supervision

This type of supervision as a process of guiding students in their work with a particular group of patients is a recent development. However, group nursing in its broadest sense has been a responsibility of nurses in all clinical areas since the beginning of the nursing profession. Nurses have always been responsible for small and large groups of patients. Accordingly, it is of interest that the group nursing supervision process has not been studied more intently until recently. Certainly, many common nurse-patient problems and observations can be effectively shared under such conditions.

Psychiatric nursing has undertaken an examination of the supervisory process of helping students work with groups of patients. Nurses are work-

ing with disturbed children, adolescents and adult patients in small organized group situations and in open or spontaneous group nursing situations. The educational preparation and specific interests of the students, and the nature of the patient's problems generally indicate the kind of group work done by nurses. The student in an undergraduate nursing program usually has an opportunity to develop basic skills as an observer, recorder and evaluator of small groups of patients. She makes observations about social group living; participates as a member and leader in the group to study her socializing role with patients; evaluates the benefits and limitations of group living in a hospital setting. Graduate nursing students and skilled psychiatric nursing clinicians are working more intensively with selected groups of patients. Some psychiatric nurses are doing group therapy with patients, working either individually or in collaboration with psychiatrists.[8,9] It is too early to assess the role of the nurse in group psychotherapy, but some very promising results are being noted.

From these major areas and trends that have been discussed, one can detect a more scientific attitude by psychiatric nurses in exploration and testing of new knowledge, and in refining and making more explicit psychiatric nursing concepts, techniques and processes.

Education and Specialization

Another major sociocultural force characteristic of our society and having a direct impact on psychiatric nursing is the extreme emphasis on continuous education and specialization. There are high social and cultural values placed on individuals who pursue advanced education. Positive social sanctions and rewards of a monetary, personal and social nature are frequently a strong motivating force for gaining knowledge and achieving deeper insights and skills. The nursing profession has been exceptionally receptive to this social trend. As Elkins states:

> It is not an exaggeration to say that nurses are engaged more actively and extensively in continuing education than any other professional group.[10]

Obviously, many of the previously mentioned changes in nursing, and specifically in psychiatric nursing, have come about as a result of nurses who have continued their educational preparation and have given leadership in the profession. Undergraduate and graduate educational programs have been noticeably improved and strengthened to prepare the practitioner for a professional role in a highly complex society and to help her relate effectively with others in a broader world society. The latter is most important since we know the boundaries of the so-called "culturally distinct societies" are becoming rapidly shaded with the increased migration and general mobility of people.

The Liberal Arts

In order to prepare this kind of a practitioner of nursing, it is the liberal arts content that provides a rich matrix in which the professional body of nursing knowledge can be interwoven both in the generalized and specialized nursing programs. Through collegiate nursing education, the student has academic opportunities to enhance her own personal life and to develop her creative, intellectual, social and professional abilities.

Opportunities to learn from teachers in other fields provide different and related subject matter to help the nurse broaden her insights about man and his behavior. Such content often serves her in a lasting way. Concepts about man's common nature, his potentialities, his creativity, his recurrent life struggles, his interaction with his fellow man and his environment, and his philosophy of life and destiny, are but a few of the precious gems that nursing weaves into the fabric of collegiate education. Such insights reduce the tendencies toward strong ethnocentrism and/or "nursing-centrisms" and keep the doors of knowledge open. Hence, liberal arts education and nursing education are most acceptable partners.

Continuing Education

Because of sociocultural changes, the many new scientific achievements in the medical field, and new knowledge and practices in nursing, continuous education is becoming a common necessity. It will no doubt be with

us for some time, as it is with other professional and scientific fields where the fund of knowledge is accumulating at a rapid pace. Porter has said that:

> The purpose of continuing education is to help nurses to improve their practice and to cope with the problems of their profession more intelligently and creatively.[11]

Whatever level of educational preparation the nurse has achieved, she will undoubtedly feel social pressures and a personal need for continuous self-study and/or advanced courses in nursing and general education.

Programs of an on-going nature for development of personnel have become an important and essential part of nursing service programs today. In psychiatric nursing there has been increased evidence of cooperation and mutual support between nursing service and education as benefits to each have become self-evident. Mutual sharing of ideas, problems and new developments are extremely useful as both work toward a common goal. The previously marked dichotomy between the viewpoints of nursing service and nursing education is becoming less marked as nursing service staff receive advanced educational preparation in psychiatric nursing, and as psychiatric nursing educators utilize the clinical setting more fully for their teaching.

Undergraduate Programs

One can find a progression in educational aims to produce both a generalized nurse practitioner and a skilled psychiatric nursing specialist. In the undergraduate psychiatric program, the objective is preparation of the nurse to function at a staff nursing (or generalized) level of practice in hospitals. In many basic four-year collegiate programs, students are prepared to function in public health nursing services. During the past five years, a concerted effort has been made to teach psychiatric nursing concepts in *all* clinical nursing areas, in addition to the student's basic psychiatric nursing experience.

Concepts and Curriculum

Teaching methods and curriculum approaches to help students to identify and to meet some of the basic emotional needs of patients in maternal and child health, medical-surgical services, and public health nursing continue to be studied. One approach has been to have a psychiatric nursing faculty member work directly with the students and the faculty in specific clinical areas. Another method has been to hold a series of seminars or discussion sessions among faculty members in order to study and examine psychiatric concepts and the teaching methods used to facilitate an interweaving of the content. Yet another very helpful approach has been the careful examination of content, learning experiences and their sequence and the teaching methods currently used in teaching behaviorial concepts throughout the total curriculum. This latter process has been very beneficial in disclosing how content in the clinical areas can be combined, reinforced, and synthesized into broader learning units. Efforts have also been directed toward strengthening the course generally identified by the title of *Growth and Personality Development* so that the inclusion of significant psychodynamic concepts of human behavior, pertinent general behavior theory, and current concepts regarding personality and ego development throughout the life cycle have been included. In several schools this course is taught quite early so that the student can utilize the content during all clinical experiences.

What is the most effective method in the integration of psychiatric concepts? What specific concepts should be integrated? What kinds of clinical learning experiences must be considered? These are unresolved questions that require continued research. In the meantime, psychiatric nursing educators and others believe that concepts such as the following should be introduced early and reinforced throughout the student's program:

> Religious and personal attitudes toward illness, attitudes about health and death; the meaning and clinical evidences of anxiety and fear; adjustment mechanisms against anxiety; recurrent family-life crises; normal dependency needs and independent strivings; the meaning of crying; expressions of aggression and hostility; social and cultural attitudes toward health and illness; emo-

tional problems associated with common psychosomatic disorders.

When the student receives her clinical instruction in psychiatric nursing, she can draw upon this knowledge and relate it in a more meaningful way to deviant modes of behavior.

During the student's experience in psychiatry, one problem which frequently arises and is somewhat disconcerting to both the student and her instructors, is the expectation by the psychiatric team that the undergraduate will function on a par with other members of the clinical team. This expectation goes beyond the student's educational preparation but could be realized by graduate students. It is a point worthy of reflection that nursing is the only professional group of the psychiatric team that provides clinical experiences on the baccalaureate level in a psychiatric setting.

Graduate Programs

Now as we turn to the graduate programs (masters, post-masters, and doctoral), one finds that the nurse is being prepared to function in leadership positions such as a clinical specialist, teacher, administrator, supervisor, consultant, and research specialist. Programs to prepare nurses for such positions have expanded greatly. Of very recent interest is the opening, in May 1960, of a new program leading to the degree of Doctor of Science in Nursing at Boston University in which psychiatric nursing is the initial clinical field of study.[12] The emergence of the clinical specialist in psychiatric nursing to work intensively with individual patients and groups of patients in giving expert nursing care is a relatively new development. Terms such as, psychiatric nurse specialist, clinical specialist and psychiatric nurse are used interchangeably to denote the nurse who uses the scientific knowledge and clinical skills that she has gained through graduate education to assist in the treatment of patients. Programs to prepare the clinical specialist place major emphasis on depth and breadth of clinical knowledge; clinical skills; critical examination of clinical problems from a research viewpoint; and experience in an intensive relationship with selected patients. More recently, a few programs have been developed to prepare competent clinicians to work with emotionally disturbed children and adolescents.

The term "nursing therapy" has been gaining rather wide use in psychiatry. Mellow, who has been exploring treatment techniques with schizophrenic patients and studying underlying principles of nursing therapy and the process of supervising others, uses the term

> . . . to describe a specific approach to the acutely ill schizophrenic patient when he is considered more or less unavailable to psychotherapy, the treatment focusing on the nurse-patient relationship . . . Nursing therapy involves a greater amount of emotional commitment and responsibility to the patient; more struggling to understand the patient and to perceive his needs, and furthermore, a greater striving to understand one's own feelings in relation to the patient.[13]

The Clinical Specialist

The need for highly skilled and clinically perceptive psychiatric nurses to work in a psychotherapeutic way with patients has become increasingly apparent. In 1958, a group of psychiatric nursing educators, psychiatrists, anthropologists, and other social scientists met in Virginia, to discuss ways in which this expert practitioner could be prepared. A report of this conference was published by the National League for Nursing.[14]

Currently, one can find clinical specialists working in a variety of health services. Some are in psychiatric facilities, while others are working in community mental health clinics. A few may be found in clinical areas of general hospitals to help nursing personnel deal with difficult patient-nurse-staff situations. Her services are being specifically requested. It was interesting to find written on a physician's order sheet, this statement, "I have requested a psychiatric nurse specialist to work with this difficult patient." Some clinical specialists are continuing to work with patients after they have left the hospital. In certain centers, the public health nurse and the clinical specialist are conferring together about particular family-patient problems that have psychiatric implications. There would seem to be

an important place for the specialist in public health agencies.

Several crucial problems exist regarding the clinical specialist's role: functions, salary, relationship with other personnel and with cultural traditions of hospital administrative practices.

Selection of Patients

In the selection of patients with whom the psychiatric nurse specialist and students will be working in an intensive relationship, one is likely to find a variety of arrangements. Certainly in the selection of a patient, one considers the level of educational preparation, clinical skills, personality factors and interests of the nurse along with the nature of the patient's behavior and illness. Patients may be referred directly to the psychiatric nurse by the physician from the general hospital or from the psychiatric service. Joint treatment plans are made.

A few psychiatric nurse specialists who have had considerable experience with psychiatric patients and who are exceptionally skilled may be found working comparatively independently with the patients, conferring with the psychiatrist as needed. Another arrangement is the selection of the patient during the on-going regular psychiatric team conferences. During these conferences, as the patient's problems and needs are discussed, the nurse considers whether the patient might be a likely candidate for nursing therapy or for a relationship experience with an undergraduate student.

The nursing staff's observations, thinking, and interpretations about the patient are extremely important. Besides contributing to the diagnostic formulation, they help the nurse to determine her plans for the patient. The nurse participates actively in the over-all treatment plan, raises questions, and clarifies her thinking with the clinical team. This is done prior to the time that she actually makes a commitment to work continuously with the patient although she has been seeing him. The initial and on-going clinical conferences help the nurse to identify some of the patient's needs and crucial problem areas, and provide clues to the behavior that she might expect during the course of the nurse-patient relationship. She shares her ideas about the way she is working with the patient and obtains information about the way other members of the team are helping him. Specific nursing care plans are generally not stated until the nurse has had an opportunity to work with the patient for a period of time.

This collaborative team approach offers certain unique values to the patient in that he has the opportunity to benefit from the professional contribution of each team member. Cooperation with other members of the psychiatric team is important and necessary if the psychiatric nurse's professional contribution is to be ultimately integrated with other psychotherapeutic efforts. There is much to be gained professionally and personally by working with the clinical group and sharing ideas and experiences together. For its optimum function, collaborative team work requires open and frequent communication among the members; periodic appraisal of the patient's behavior and treatment goals and a comparatively mature professional team.

Problems

Difficulties arise particularly in the area of communication and coordination of each member's efforts. The psychiatrist's leadership role and his full knowledge of what each team member can contribute is extremely important. Another problem that commonly occurs is the tendency to cast the psychiatric nurse in the traditional role of a "medicine nurse" or "physical-care nurse" or "an administrative nurse." Seeing her in a supportive relationship role and other roles with patients may be difficult for those who are strongly attached to tradition. A pressing problem facing psychiatric nursing is to provide an adequate number of qualified psychiatric nurses for the supervision of nursing relationship work and nursing therapy with patients. In some centers, psychiatrists have an active part in the supervision of the nurse's work with patients.

The Therapeutic Community

Another aspect of psychiatric nursing in which the nurse has a major responsibility and can directly influence

the outcome of treatment concerns her role with patients in the social environment. Concepts and definitions of therapeutic social environment and of a therapeutic community are rapidly accumulating. One attribute of the community which seems dominant, is expressed by Gralnick, "It has a conscious design and its main aim is to help the patient to become a more mature and rational person . . ."[15]

It is clear that before one can consciously direct and bring about changes in social structure in a given hospital community, the first step is to examine the nature of the structure and the interpersonal relationships found in a given setting. It is in the social situation of group living that the nurse can be an active participant in making scientific observations and objective appraisals of staff interactions as a conscious part of her therapeutic responsibilities. Sampling group living patterns between staff and patients during the 24-hour period can provide pertinent data for cognitive changes in the patterns of treatment.

There is still a tendency for the clinical team to maintain established treatment rules and policies for long periods of time. Such a plan does not fully recognize that there is a constant turnover in the patient and staff population of hospital units. Social environment planning should be based largely on the social structure and community from which the patient came and the on-going patient-staff interactions in the hospital environment. Milieu programs need to be perceived as flexible, changing and very sensitive plans, that meet the needs of the present situation. In some centers, there is a tendency for nursing personnel and others to over-structure and to be actually in control of the patient's life in very subtle ways. Patients need an atmosphere with elements comparable to the social life outside the hospital. Social scientists are still expressing concern about the problem of knitting the hospital environment more closely to the community in order to reduce isolation, stress, rejection and fear of utilizing hospital services.

As Devereux has stated, "The therapeutic social environment must be reasonably compatible with the mores of that segment of society in which the patient is ultimately expected to live."[16] The group living situation needs features that help the sick portion of the patient's personality and ones that help the healthier aspects. The provision of elements in the social environment that stimulate the patients to feel free to talk about what they want, what they have done, seen, or heard is as important as preserving the spontaneity, natural interests and talents of the staff. Blending these elements into a treatment milieu requires the nurse's participation and her knowledge of the community, the staff and the patient group.

We still have a number of cultural expectations in our psychiatric units: all patients must go to occupational therapy; all patients must go to the ward party; all patients must eat at the same time. Are these real needs of the particular group of patients? Or, are they ego satisfactions of the staff in that something is being done or offered to the patients? Remnants of our cultural expectations can be found in the grouping of patients by age, sex, social status, acuteness or chronicity of illness. What are the most effective grouping patterns for therapeutic group living? We need more research into and experimentation with the social grouping of patients, particularly in relation to the social organization of the hospital and the social relationships of staff members. The nurse can have a part in this endeavor. We also need to think about the qualities of professional leadership that are most effective for group living situations, and for patients having different psychiatric problems and needs.

Social Structures and Social-Cultural Concepts

Daily group living experiences based on health-promoting staff-patient interactions and interventions can be one of the most important, determining aspects in the treatment of patients, once we know more about what we are doing and can critically examine the results. Knowledge of the elements of social structures and of social-cultural concepts of healthy living patterns in our society would help to advance our progress toward a therapeutic community. Effective processes

of decision-making, the locus of power in psychiatric hospitals and ways to implement decisions effectively could bear more research. Our recent innovations of the "open door" policy, day and night care programs, group government, remotivation programs and others, need further exploration. To what extent are nurses involved in studying and evaluating such areas? Where should the power reside in the planning and development of milieu therapy programs? All too frequently the nurse implements decisions made by others regarding the social environment.

Another area of concern that influences social treatment plans and nursing responsibility is the culture value regarding the concepts of progress and recovery. Our Western society measures progress and recovery of patients in terms of *how soon* the patient can get out of the hospital. Early ambulation, self-help and rapid treatment methods reflect the impact of our economic and social systems on health practices. Generally, progress that lies in the best interests of the patient is favored, but often one can see where the patient, nurse, psychiatrist and other members of the clinical team are unconsciously caught in this growing social pressure and high cultural value of early dismissals. Patients "weave out" of hospital and sometimes "weave back" in a short time often having given clues before they leave of their doubtful readiness to maintain their health equilibrium. The nurse is frequently in a strategic position, through her daily observations, to offer supporting data concerning whether the patient is ready to leave or to give ideas about a continuing care program outside the hospital. To what extent does the nurse offer her observations and to what extent are they used in this important decision? Progress and recovery are difficult to determine since our criteria for measuring them are not explicitly stated. It is even more difficult if our knowledge about the social environment in which the patient has been living is scant.

As we look to the future during the next decade, one can hope that multi-disciplinary research will point to more precise knowledge and understanding of specific sociocultural factors influencing mental health and psychiatric illnesses. Perhaps we may find out how mental illness and its treatment differ in western societies and are similar to that of non-western societies, and how such knowledge can help us to have a wider understanding of human behavior and man. One can already see some general cultural and social factors that are beginning to pose problems that forecast still greater changes in psychiatry and psychiatric nursing.

1. The increased mobility of people due to rapid transportation facilities, international work, and general migration trends. This will produce heterogeneous societies and natural social stresses that affect the mental health of individuals.

2. World problems with their unpredictable character. These tend to reach individuals and groups in a personalized and stressful manner.

3. The unequal development of social and cultural innovations within a society and between societies. These are potentials for psychological stress. Transitional stages between the forces of change and the forces of stability are even greater sources of tension.

4. Scientific advances and findings in psychosomatic medicine. These imply greater integration of psychological, physical and sociological aspects. The psychosomatic approach will no doubt call for greater skills and knowledge in medical and nursing practice which will necessitate a high quality of performance in the future.

5. Increased dissipation of feelings of shame, fear, and social stigma regarding mental illness. This will result gradually in greater willingness of people to accept psychiatric help and to do so at an earlier stage.

6. The mounting problems found in childhood, adolescence and advanced age. These will continue to require psychosociological understanding and direct help.

7. Our movement to meet and work with people in community settings away from hospitals. This will demand a greater number of psychiatric personnel.

Future Trends

The foregoing are a few of the factors that will make heavy demands on psychiatric nurses, psychiatrists,

social workers, public health nurses and others in the future. With a limited number of psychiatrists and an increased number of psychiatric nurses, it seems quite reasonable to predict that with increasing frequency the psychiatrist will delegate some of his therapeutic responsibilities to highly competent psychiatric nurses who have preparation, clinical knowledge and skills to deal with the somatic, psychological and interpersonal problems of patients. The psychiatric nurse will probably play a vital role, especially in the acute phase of the patient's illness and in working with patients who need a prolonged supportive relationship. Her ability to make scientific observations and perceptive judgments and to work therapeutically with patients will be extremely important. There are already indications of the psychiatric nurse specialist working in an ego-supporting and corrective relationship role with patients.

In the future, one can also anticipate that basic clinical research in psychiatric nursing will have high priority and great significance as the essential components of therapeutic practices in psychiatric nursing are identified and validated. Basic clinical research will be the foundation upon which psychiatric nursing theory will continue to develop. Interdisciplinary research with the psychiatric nurse as an active participant should help us to determine what techniques, therapeutic experiences and specific treatment measures are significant in the patient's total therapy. More explicit knowledge of the contribution of each member of the psychiatric clinical team and of the total treatment process with its long-term effects would be most useful knowledge for the educational preparation and effective utilization of psychiatric personnel. It is also safe and logical to predict that more and more psychiatric nurses will continue to work in community health treatment centers in close cooperation with public health nurses and other health groups in the community.

Conclusion

The age of scientific inquiry, specialization and continuous education has led to significant and fundamental changes in psychiatric nursing. A substantial move is being made by the psychiatric nurse towards assuming more responsibility for the psychotherapeutic treatment of patients. It appears that she will have an even greater part in the future. The scientifically-oriented approach to nursing problems; the interweaving of psychiatric nursing concepts into all areas of nursing; the significant use of nurse-patient interaction processes; the emergence of the clinical specialist; clinical research; and the general progress toward very favorable changes in undergraduate and graduate nursing curricula have produced a great impetus toward the "new frontier" in psychiatric nursing.

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IN MEMORIAM

(Continued from page 938)

Marion (Miller) Hepburn who graduated from the Montreal General Hospital in 1906 died in June 1960.

* * *

Wilhemina (Blankenvoort) Hepburn who graduated from St. Joseph's Hospital, Victoria in 1925, died recently.

* * *

Kaye (Provis) Jones who graduated from Ladysmith General Hospital, B.C. in 1920 died during June 1961, in Ladysmith. She had retired in May 1961 from the position of operating room supervisor of the hospital.

* * *

Helen Kirk, a graduate of St. Michael's Hospital, Toronto in 1943, died on September 12, 1960 in St. Paul, Minnesota.

* * *

Blanche Lecompte who graduated from Hôpital Notre Dame, Montreal in 1919, died on August 4, 1961 after a long illness. As a member of the ANPQ Committee of Management in 1929, she took an active part in planning for the congress of the ICN held in Montreal that year. She organized and was the first director of the Société des Infirmières Visiteuses in the province of Quebec. For several years she engaged in occupational nursing with National Breweries.

* * *

Frances Aileen McCarthy, a graduate of Vancouver General Hospital in 1931, died June 12, 1961.

* * *

Lila Carmen (Budd) McFarlane who graduated from the Montreal General Hospital in 1923, died June 19, 1961.

* * *

Ida McQuillan, a 1914 graduate of St. Michael's Hospital, Toronto, died May 11, 1961. Her professional life was devoted to private nursing in Toronto and New York.

Mother Beatrice St. Louis, a graduate of St. Vincent's Hospital, Toledo, Ohio, died in Montreal on June 9, 1961. A member of the Grey Nuns of Montreal, she served as director of nurses and superior of the Grey Nuns' Hospital, Toledo and in other capacities before her election as superior general of the order in 1957.

* * *

Lena (Charpentier) O'Connell, a graduate of St. Michael's Hospital, Toronto in 1924 died in Toronto on April 28, 1961. Her professional life was spent in private nursing.

* * *

Margaret L. (Mason) O'Leary who graduated from St. Joseph's Hospital, Victoria in 1921, died recently.

* * *

Gertrude Patton, a graduate of St. Michael's Hospital, Toronto in 1912, died on June 4, 1961.

* * *

Gertrude Pearce who graduated from Victoria Hospital, London in 1921, died June 16, 1961.

* * *

Helen (Pewtress) Robinson, a 1945 graduate of St. Michael's Hospital, Toronto, died in Calgary on June 8, 1961.

* * *

Marion Phyllis (Ryalls) Sangster who graduated from St. Boniface Hospital, Manitoba in 1940 died in Stoughton, Sask. during July, 1961.

* * *

Grace (Huff) Scroggie who graduated from Royal Victoria Hospital, Montreal in 1906 died in Kingston, Ont. during June, 1961.

* * *

Meta (Valleau) Smith who graduated in 1929 from Clifton Springs Training School, New York died in June, 1961 at Memorial Hospital, Campbellford, Ont. She had been on the staff of the hospital for several years.

NURSING PROFILES

Sheila Margaret Imelda Quinn joined the staff of the International Council of Nurses in August to assist in developing an Economic Welfare program. Extensive study in the fields of economics, economic history and sociology — she obtained a bachelor of science degree in economics from London University — has given her an excellent background. Miss Quinn also studied administration and teaching at the Royal College of Nursing, London. She has travelled widely and has comprehensive understanding of conditions in many countries.

Prior to accepting this present position, Miss Quinn was principal tutor at the school of nursing, Prince of Wales's General Hospital, Tottenham, London.

Ingrid Margaretha Hamelin has been appointed assistant to the director in the Education Division of the International Council of Nurses. She began her new duties in August.

A graduate of Helsinfors City School of Nursing in Finland, Miss Hämelin later specialized in X-ray technique. Postgraduate studies have included nursing education and administration at the College of Nursing, Helsinki and at the University of Chicago as the recipient of a WHO fellowship. In addition, she took a course in management at the Helsinki Institute for Industrial Training.

Miss Hämelin has held senior professional positions in Finland and England. Immediately prior to her new appointment, she was instructor in nursing service administration at the College of Nursing, Helsinki.

The Registered Nurses' Association of Ontario has announced the appointment of **Doris Elizabeth Gibney** as assistant executive-secretary. A graduate of Soldiers' Memorial Hospital, Orillia, Miss Gibney secured her certificate in nursing education from the University of Toronto in 1945 and her bachelor of arts degree in 1959.

She has held a number of senior positions in nursing, having served as a former assistant director of nursing at the Soldiers' Memorial Hospital and at the Toronto Psychiatric Hospital. Miss Gibney has taken an active part in provincial affairs over the years as councillor for District No. 5; psychiatric consultant to the panel of examiners, RNAO; member of the RNAO sub-committee on planning for conferences, and in other offices.

(Ashley & Crippen, Toronto)
DORIS GIBNEY

The new director of public health nursing with the Saskatchewan Department of Public Health is **Eleonore Louise Miner.** Following her graduation from the Royal Alexandra Hospital, Edmonton, Miss Miner spent a number of years in general nursing in the western provinces before coming to the University of Toronto to study for her diploma in public health nursing. In 1949 she com-

(West's Studio)
LOUISE MINER

pleted requirements for her bachelor's degree in nursing at the School for Graduate Nurses, McGill University. Further study at the University of Michigan secured her Master's in public health.

Miss Miner was employed in supervisory positions in various health units throughout Saskatchewan for a number of years before becoming consultant to the Saskatchewan Department of Public Health. She has acted in this capacity for the past six years.

SISTER FRANÇOISE DE CHANTAL

Early in August **Sister Françoise de Chantal** began her new duties as director of the nursing department at the University of Ottawa. A graduate of the Ottawa General Hospital and of the University of Ottawa where she obtained her B.Sc.N., Sister later secured her Master's degree from Catholic University of America, Washington, D.C. Since 1952 she has been director of nursing at the St. Elizabeth School of Nursing and St. Joseph's Hospital, Sudbury.

Her association with the University of Ottawa is long-standing. She had previously been director of the undergraduate program in nursing for a seven-year period and director of the postgraduate program for one year. In assuming her present responsibilities, she is on familiar territory. Sister's interest in nursing and professional activities is well-known. She is a councillor on the executive of the Canadian Conference of Catholic Schools of Nursing; treasurer of District No. 9, RNAO; member of the RNAO Committee on Nursing Education and of the Ontario Council of Nursing — an advisory body to the Minister of Health.

Muriel C. McArthur, matron-in-chief of the Canadian Forces Medical Services has been promoted to the rank of Wing Commander, RCAF. A graduate of the Toronto General Hospital, she first joined the armed services in 1941 and, after two years' service in Canada, was posted overseas to Yorkshire, England. Following her return to Canada in 1946, she was assigned to various bases here and eventually in 1954 became Command Matron of the RCAF's European-based Air Division. She has been in her present position since September 1960.

In addition to this significant promotion in rank, Miss McArthur who is on the Nursing Advisory Committee of St. John Ambulance Headquarters was recently admitted to the Order of St. John. She will be invested by the Governor General at a ceremony this autumn.

An Ontario nurse has been awarded the Marjorie Hiscott Keyes White Cross Medal in recognition of her outstanding work with mentally retarded persons. **Mary Tero,** a graduate of Kingston General Hospital, has been on the staff of the Ontario Hospital in that city since 1944.

(Ontario Dept. of Health)

MARY TERO

At first, Miss Tero worked with elderly patients but later she was appointed supervisor of a group of newly transferred mentally retarded individuals. Bewildered and confused by the strange surroundings, they could not function even within the limited scope of their capabilities. Miss Tero, sensing their bewilderment and showing unusual understanding of their problems, was able to effect an almost miraculous transforma-

:ion in their behavior. Under her guidance, patients who had refused to remain properly dressed or to feed themselves, were taught to play simple games and to take some interest in personal appearance. The entire atmosphere of the ward brightened. Other personnel followed Miss Tero's example of enthusiastic, dedicated service. The citation accompanying her award notes that "her interest in the patients, her cooperation and loyalty, have established an ideal in psychiatric nursing standards for personnel in all sections of the hospital."

(National Health & Welfare)
DOROTHY PERCY

Dorothy M. Percy, nursing consultant for the Department of National Health and Welfare, and **M. Pearl Stiver,** executive director of the Canadian Nurses' Association have been admitted to the Order of St. John. They are members of the Nursing Advisory Committee of St. John Ambulance Headquarters and of the Award Committee of the Countess Mountbatten Bursary Fund. Miss Percy and Miss Stiver will be invested by the Governor General at Government House this autumn.

National Headquarters of St. John Ambulance has also announced the recipient of the 1961 Countess Mountbatten Bursary. **Dolores Chapelle,** who has completed her first year at the University of Saskatchewan School of Nursing, was chosen to receive the award from over 80 applicants. Special awards were made to **Judith Rose** who has completed her first year at the University of Toronto and to **Francine Filion** who has completed one year at Institut Marguerite d'Youville and two and one-half years at

(Paul Horsdal Ltd., Ottawa)
PEARL STIVER

Notre Dame Hospital School of Nursing, Montreal. All three students had outstanding qualifications and were highly recommended by their directors of nursing.

Kathleen Fardoe has been appointed supervisor of the outpost hospital department of the Ontario Red Cross Society. A graduate of a hospital in England, Miss Fardoe's first venture abroad was to Belsen, West Germany under the Save the Children Fund where she helped to look after children being moved from the concentration camp. Later, after four years spent in district nursing in England, she went to Hong Kong to work among the refugee people there.

Miss Fardoe first came to Canada in 1957 and engaged in public health nursing under the Ontario Department of Health. She joined the Red Cross Society in September 1960. Her enthusiasm about the work being done in the 17 small hospitals and seven health centres in Ontario and her concern over staff shortages prompted a recruiting trip to England with good results. To Miss Fardoe, work in the outpost unit offers the nurse an opportunity to put into practice the many techniques that she has learned during her training. The unit exists to meet emergency needs and the nurse is put on her mettle since she must be prepared to deal with the unexpected at all times.

Mary P. Edwards, director of the public health nursing division, Department of Pub-

MARY EDWARDS

lic Health, Saskatchewan since 1953, has retired from active nursing.

Miss Edwards graduated from Regina General Hospital in 1933 and spent the succeeding four years in private and general duty nursing. In 1938 she became residence supervisor at RGH, a position that she held until her first association with the Saskatchewan Dept. of Public Health in 1942. Her duties as a staff nurse with the nursing division were interrupted for study at the University of British Columbia where she obtained her certificate in public health in 1944. In 1947 Miss Edwards was promoted to the position of supervisor and in 1952 she completed requirements for her bachelor's degree in nursing from the School for Graduate Nurses, McGill University. A Rockefeller travelling fellowship in 1946 had given her an opportunity earlier to obtain her certificate in midwifery from the Maternity Centre, New York.

Miss Edwards has had a very full, very busy professional life. Although retirement will permit time to indulge in her favorite hobbies, it is to be expected that her experienced counsel will be sought by many in the future.

In 1959, a pilot project in home care sponsored by the provincial division of the Canadian Red Cross Society was started in Grande Prairie, Alberta with the cooperation of the local Health Unit, the Alberta Civil Defence program and the St. John Ambulance Brigade. The objective was to encourage women to take instruction in home nursing and first aid so that they would be prepared to offer helpful service.

Early this year **Nora Ruth Trottier** was appointed to act as nurse consultant to the project. A housewife herself, Mrs. Trottier plans to use her own home as headquarters in carrying out her responsibilities for organization of courses and instruction. She will also serve in an advisory capacity to those persons who have completed Red Cross home nursing training.

NORA TROTTIER

Mrs. Trottier is a graduate of the University of Alberta Hospital, Edmonton. She previously worked on the staff of St. Joseph's Hospital, Dawson Creek, B.C. and the Municipal Hospital, Grande Prairie. Most recently she was associated with the Dobson Medical Clinic in Grande Prairie.

To help take the mystery out of cerebral palsy and to enable children to live with it comfortably is the objective of a new pamphlet "Growing Up — Cerebral Palsied Children Learn to Help Themselves."

The author, Mrs. Mildred Shriner, draws upon techniques and methods utilized successfully in clinics and special classrooms to provide concrete advice and guidance for parents.

Copies are available, at 25 cents each, from the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Ill.

THE WORLD OF NURSING

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Interim Report

GLENNA ROWSELL, Director of the CNA School Improvement Program is making a trans-Canada tour attending two-day regional conferences to interpret the program that is aimed at assisting schools to upgrade their educational programs. To date, 150 of the 170 schools of nursing in Canada have indicated their willingness to participate in this program. A 32-page questionnaire has been completed by these schools. The questionnaire dealt with such matters as the philosophy and objectives of the school, queries about organization and administration, the faculty and students, the curriculum and physical facilities of the school.

Many of our university schools of nursing have indicated that they are happy to participate in the program; others that they will give assistance with conferences and workshops in their regions. All planning for these conferences was done by the CNA through the provincial nurses' associations. Key persons in provincial health and educational fields have been invited to sit in for the first half day of each conference. Miss Rowsell's role at the conferences is to interpret the program to hospital nursing staff.

These two-day regional conferences commenced in Alberta in September, there will be at least one in each province. To date, conferences have been held in Calgary, Edmonton, Saskatoon, Regina and Winnipeg. Dates have been set for six conferences in different regions of Ontario between October and the first of February. Quebec has planned three conferences, one each in English and French in Montreal and one, French, in Quebec to take place in November. Prince Edward Island has planned a conference for mid-October.

Self-evaluation guides will be sent to the schools participating. An immediate purpose of the self-evaluation guide is to assist schools in identifying the areas in which improvement is desirable and practical, and where assistance is required. These guides are to be completed and sent in to National Office by May, 1962. A special committee will be set up to review them.

Victorian Order Of Nurses

The VON established a "first" in their organization throughout Canada, with the appointment to the staff of their Vancouver branch of a male nurse, Mr. FRANK BRYANT, R.N. Mr. Bryant is a 1956 graduate of St. Paul's Hospital School of Nursing in Vancouver. His VON appointment was in response to a request from the Canadian Paraplegic Association.

Nursing Unit Administration

Representatives of the Canadian Nurses' Association brought greetings to the students at the opening session of the Nursing Unit Administration workshops in August and September at Vancouver, London, Toronto, Halifax, Winnipeg and Edmonton.

Pursuit of Knowledge

Miss MARIE DE CHAVEZ, RN, BSN, RM, from the Philippine Islands came to Canada in 1960 to further her study of nursing. A graduate of the Chinese General Hospital School of Nursing under the Immaculate Conception Sisters of Canada, Miss de Chavez has taken a postgraduate course in public health nursing at the University of the

Philippines, received the Bachelor of Science in Nursing, majoring in teaching and administration of public health from Arellano University, followed by a Master of Arts with a major in administration and minor in English and psychology. Miss de Chavez has had a broad experience in many fields of nursing, particularly in British Columbia.

She is now working on her thesis on the theoretical and practical side of nursing, as well as writing articles on the best methods of nursing as observed by her in all of the hospitals where she has worked. There is a real emphasis on education in the Philippines. Materially they may be a poor country, but it is a country rich in knowledge. We are fortunate to share our working knowledge with a person of such calibre.

Teaching Mental Health to Nurses

PEGGY C. PIKE

Mental illness can be found anywhere; therefore we must prepare our nurses to meet this almost overwhelming burden, adequately and competently.

THE BASIC TRAINING schools are devoting more time and money to adequate experience in basic psychiatric nursing. As a result, large provincial hospitals have increased their teaching staff and improved general facilities to provide it. Some centres are prepared to give postgraduate courses to extend the skills learned in undergraduate training. Beyond these levels, we have universities across the country giving advanced courses to the nurses who decide to specialize as instructors or supervisors in this field. However, for many a nurse, the in-service program is still the only opportunity she may have to increase her knowledge of psychiatry and the psychiatric care of patients.

The training given to the undergraduate nurse is geared to help her understand emotional problems, mental illness, the current treatments and medications. It is hoped that she will learn to accept the mentally ill, lose some of her prejudices and learn the principles of psychiatric nursing care. Out of this experience, the student usually develops a greater awareness of her own reactions to other people. She may decide, too, that she wants to learn more. The next step then is to take a postgraduate course, go to university, or do both. Whether or not the student returns to the field of psychiatry, her knowledge should be of assistance to her wherever she nurses.

The student may find it extremely difficult to apply her psychiatric knowledge if the graduate staff rejects the principles of psychiatric care. Nurses who have not had basic training in psychiatry — and there are many — tend to feel inadequate with an obviously mentally disturbed patient. This is not helped when a young student, after her psychiatric training, appears on the scene with a few ideas of her own about what to do.

Those of us in psychiatric units can be very helpful in this area; there is much that we can do, on an in-service level, to lessen the problem. We can offer to give a series of discussions — not lectures — on the general approach to these patients. We can indicate our willingness to act as consultants when ward problems arise. Most decidedly, we should give all staff members a chance to visit our units.

The progress of any patient transferred from a medical, surgical or obstetrical unit to ours can be reported. We like to know how our patients fare under their care; they, in turn, are just as likely to wonder how their

Miss Pike who was formerly the instructor is now in charge of the nursing research department of the Allan Memorial Institute, Royal Victoria Hospital, Montreal.

patients are getting along. We must accept the fact that a psychiatric patient on a large ward is a greater problem than one on a unit prepared for his behavior. The emotional, physical and intellectual barriers between psychiatric and general hospitals must be removed before we can be of mutual assistance. When this is recognized and accepted, we will have made a great step forward in the care of the mentally ill, for the nurse will be taught to see the patient in the light of his total needs — physical, emotional and spiritual.

The postgraduate student must be given the opportunity to practise psychiatric nursing, and attention must be directed toward her education. Her knowledge must be extended through further discussions directed by experienced nursing staff, psychiatrists and psychologists. Care must be exercised not to use her simply as additional staff, although this is frequently a temptation hard to sidestep. The social service department and the sociologist can be utilized to expand the nurse's awareness of community aspects and their implications in the course of, effect on and care of the mentally ill.

If the nurse decides to attend university, she will find more emphasis placed on theoretical background: Sociology, psychology, economics, statistics, and so forth. This is necessary and right if we hope to increase our status as a professional group. The nurse, before going on to this level, must prepare herself as thoroughly as possible in the applied field of psychiatric nursing.

The occupational health nurse has a special problem, communication with other groups. She tends to be isolated. Nevertheless, the desire to give more than she has heretofore to those under her care is increasingly apparent. Seminars and discussion groups with the staff of available psychiatric units can be arranged through her association. A willingness to exchange and share information is not lacking. Those of us in a hospital setting can learn a great deal from the experiences of these nurses. The public health nurse also has a broad background of community awareness. We can support her in selected problems that come to her attention—again, by mutually beneficial seminars and discussion groups.

Instructors in Psychiatric Nursing

The quality of the psychiatric nursing instructor is vitally important for she introduces the students to a vast and sometimes controversial study of human behavior. Her awareness of the needs of people cannot be discarded when she steps from the ward to the classroom. The impact of the theory of psychiatry awakens questions in the mind of the student. Some of the concepts are not readily acceptable. Only experience and observation of the patients will give them substance. The instructor learns to move slowly and wait for practice and theory to blend. She must also accept the nurse's identification with psychiatric illness. When she starts her training, a student nurse may dramatize a "common cold" with visions of pneumonia and impending death. Just so, the psychiatric nursing recruit may visualize her mild feeling of depression as the first step in the direction of an acute manic-depressive state. The skilled instructor knows this and does not belittle it, but relates it to the nurse's reactions in other fields of nursing.

The introduction of the nurse to the psychiatric patient must revive memories of the sense of inadequacy she experienced when first faced with a ward of patients. The instructor, the head nurse and the doctor all share the responsibility for minimizing this feeling of impotence. The instructor, with her planned theoretical introduction, the head nurse with her appreciation of the practical aspect, and the doctor with his understanding of the emotional impact of these patients on the nurse can form a strong resource team.

The improvement of treatments, the strides in psychiatric knowledge and the introduction of new medications have all contributed to the psychiatric patient's early return to the social milieu. Therefore, the role of the social worker is related to that of the nurse to a greater degree than it was at the time of long-term commitment. This indicates the importance of the nurse having an awareness of the functions of this department, in order to synchronize their efforts in making the

patient's after-care plan arrive at its greatest possible effectiveness.

The psychologist has a dual role in the education of the nurse. She must have an appreciation of what is normal in behavior. This knowledge cannot be introduced too early in the nurse's training. A firm foundation in human motivation, defence mechanisms and stages of psychological development are essential for the day-to-day relationship with all types of patients. However, when the student starts her psychiatric training, she appears to need a reaffirmation of these concepts. If it is not done, the nurse tends to be overwhelmed by abnormal and to lose sight of normal reactions. The second role of the psychologist is the explanation of psychology tests, their value and place in the treatment of the patient. With this knowledge, the nurse works more intelligently and sympathetically when coping with a patient's misgivings about them.

The change in hospital care — the closer relationship between the community and hospital — indicates the importance of the nurse developing a greater knowledge of the word around her. World travel increases as world-distance lessens. The mingling of cultures brings sharp awareness of differences. For the nurse to appreciate the patterns of her own society and the impact of one culture imposing new trends on another, she needs some appreciation of sociology. We cannot expect a change from the outside, regardless of how health-giving and important we feel it is, without emotional stress because of old accepted beliefs and customs.

Teaching Psychiatric Nursing

The instructor has to develop an approach related to her subject. The size of the class is important. Ten students at one time is the most an instructor can teach and observe with comfortable effectiveness. This small number opens the way for discussion. By permitting the student to tell the instructor and her classmates about her difficulties on the ward, she so often finds that she is not alone. For example, if a psychopathic patient makes a student feel inadequate and ineffective, she is reassured when several other nurses have had similar reactions. When such problems are aired and discussed helpfully, student anxiety is minimized. All student problems should be worked through as they arise. This means an instructor has to be flexible and not obsessed with keeping her timetable as neat as an unplayed chessboard.

The best period for psychiatric affiliation is near the end of the second year. The student has consolidated her basic theory and practice into a familiar pattern. What she does not feel comfortable about, in psychiatry, is offset in some measure by the confidence she has in her ability to do bedside nursing.

Affiliation that starts too early has disadvantages, but if too late it has definite limitations. The student so often mistakenly feels that her psychiatric training will be of no use now because she is almost finished. It is true it would have helped her handle the difficult patients she was confronted with in the past. So often the ideal course of events in the young nurse's mind is training, then marriage. This is a natural goal and it is gratifying to realize the students maintain a feeling of romance. Nevertheless, married or not, graduates frequently continue to care for patients. In addition, the principles learned in psychiatry are applicable in all interpersonal relationships.

One way to avoid departmentalization of the study of human behavior and reactions, of course, is to teach psychiatry throughout the entire course. The presentation of material embodied in the study of behavior, both normal and abnormal, creates reactions in the recipient that the instructor must appreciate. The patient is of no help. If she is overactive, loud and aggressive, the student is overwhelmed; if she is quiet and withdrawn, the student is baffled; and if the patient is reasonable, the worried student is almost ready to volunteer for her place in the ward. The task of the instructor is to make these situations understandable and acceptable.

For so many nurses the histories and the actions of the patients are frightening and distressing. Students are both rigid and naive. Signs of uneasiness are recognized by their behavior. The student who argues a point

round and round; the one who asks vague philosophical questions; the giggler and the forgetful daydreamer may all be having difficulty with the material being presented. Individual support rather than criticism will help the student. The instructor should assure the nurse that it is not always easy to accept new ideas and eccentric behavior in others, but she understands and appreciates the student's dilemma.

One measure of acceptance of the mentally ill, not consciously recognized by the student, is the intellectual one. By keeping her interest on dynamics and the textbook, the nurse protects herself from emotional concern and is, theoretically, a good student. The theoretical student may do exceedingly well, but one who tries to understand and accept is the potential psychiatric nurse.

One practical problem facing all students of psychiatric nursing is charting. They learn new terminology, then we warn them to be careful about applying it. If, for example, the nurse charts the patient as "paranoid" we want her to state why she has this impression. We want her to use precise, descriptive words and good sentence structure. These, unhappily, are not always easy accomplishments for many nurses. Since this is so, we must be prepared to devote much attention and help toward encouraging their efforts if we wish to be spared pages of "patient socialized well" or "slept well." There is a secondary gain here, for besides learning to express herself precisely, the nurse finds she has to observe her patients closely for her charting material.

The care of the mentally ill is a thinking and evaluating process. Superficial impressions are not enough; the nurse cannot help the patient by blind acceptance of his outward actions. She must adopt the "how" and "why" of the newspaper reporter. How does the patient react to those around him? Why does he not eat? The nurse must always be alert to observe, anticipate and communicate patient reactions. Experienced psychiatric nurses are the ones who point out, explain and interpret patient behavior.

We have all been taught that the patients are individuals and this is even more true when we are looking after the mentally ill. These people are individuals in time as well as in person. Their mood changes daily, hourly. Treatments, medications and psychotherapy all make their imprint. The nurse has to learn all there is to know about these treatments to help her appreciate and anticipate their effectiveness on patients.

An extremely difficult aspect of psychiatric nursing is literally approaching and talking to patients. The student who talks enthusiastically all through class may be speechless when confronted with a patient. She has one great fear: she might say the wrong thing! Mercifully, she seldom does. However, if the student is told she can always get support from the staff if she does think she has made a mistake, she becomes more confident. In fact, she can be assured that she is more perturbed than the patient.

Another important point for the nurse to learn is when to talk and when to be silent. Rapid chatter will not do anything for a withdrawn patient, and will only act as a stimulant for an overactive one. As the student becomes more sensitive to the needs of these patients, she becomes intuitive in her judgment. This we must help her to accept as something that will occur as she gains experience.

Finally, the nurse in caring for the mentally ill learns to change the emphasis of her nursing care. The emotional needs of the patient transcend those of the physical. Nevertheless the two are never truly separated. We must guard against letting the nurse slip into the habit of referring to all physical complaints as hysterical. If they are neurotic in origin the patient is still ill, or he would not be compelled to use such defences for his problems. On the other hand, he may have a genuine physical illness. This is a decision for the doctor to make and not for the nurse to decide arbitrarily.

Psychiatric Nursing and the Patient

To appreciate the psychological effect of the mentally ill on the nurse, we must consider the effect of the illness on the patient. Control of the emotions may be lost or distorted. The nurse is expected to meet outbursts of

temper, demanding behavior or childish reactions with equanimity. True, she has her own level of tolerance and cannot be too severely criticized if it is reached. We can help her if we are alert to her needs. She should be removed from the situation if she is becoming irritable or intolerant. A change of pace, work in the office, a trip to the occupational therapy department; anything to relieve the pressure and give her freedom to regain her emotional equilibrium will help. The long-term point of view should be stressed for the demanding patient of today may be the giving one tomorrow.

Rapid rotation from one ward to another fails to give the student the opportunity to receive the satisfaction of working through, with the patient, the difficult stages of illness toward recovery. The personal dignity of the patient may disappear. It is distressing for students to hear profanity and to witness unclean personal habits. Regression in adults is hard to accept. Disgust and rejection are difficult to control. Once again the student has a new lesson to learn. If she can see the relationship between the unpleasantness of physical illness and the uncouthness of psychiatric illness, she has gone forward in her understanding.

Discouragement is another reaction of the nurse, particularly in relation to the length of the patients' illness or the repeated admissions of certain types of patients. She is able to accept the long course of tuberculosis or the readmissions of the cardiac patient. Once again a parallel can be drawn between psychiatric and physical illness.

The student must learn that special skills are needed to motivate the underactive patient. It is not simply a matter of telling him to get busy and then he will feel better. Nor should she decide his behavior is due to laziness or lack of will power. This is a patient who is defeated. He may well think that to do things may lead to failure. The nurse must learn to go slowly, encourage any sign of activity and bolster the patient's ego by indicating that she appreciates him.

The overactive patient needs quietening influences. This is sometimes hard for the nurse to learn. She sees the patient as a bright spot on the ward and encourages his enthusiastic responses to all stimuli. This can go on until the patient becomes irritable or exhausted. We must teach her to act as a control, for these patients can be compared to children who cannot stop when they get overexcited. Quiet responses, removal from other people, never responding to sarcasm with sarcasm, are essential to promote his well-being. This is not easy. Some students only appreciate the wisdom of these suggestions after many exhausting encounters.

Withdrawn patients are a challenge. Most nurses have a wonderful feeling of satisfaction when they see these patients begin to interact with the people around them. The patient's withdrawal is a barrier he has erected to protect himself from further hurt. He does not trust people. The nurse has to build up his faith. When he knows that she is reliable, that she keeps her promises, talks to him or sits beside him without making demands, he gradually accepts her. It is crucial that the nurse learn to move gently and expect little in quick return for her efforts. The slowness of these people to respond may discourage the nurse, but it cannot be hurried.

The neurotic patient, closer to us in behavior, is the most difficult, in some ways, for the nurse to accept. The apparent normalness of the patient can lessen the student's tolerance for the demanding, dramatic, obsessive or anxious manifestations of his illness. She expects him to react to frustrations and disappointments with the control she demonstrates. If he does not, he is apt to be classed as an uncooperative or difficult person. This is where the student's knowledge of behavior mechanisms is put to the test. If she has learned the normal defences to life's problems, practised by everyone, she sees these exacerbations for what they are in people with a lowered ability to withstand stress.

The patient's relatives have a great bearing on the emotional health of the patient. In a general ward the nurse has little time and probably little incentive to spend time with the visitors. The nurse on the psychiatric ward must note the reactions and inter-reactions of the patient to his family

if she is to fully understand him. The student must be taught to observe the patient before, during and after visiting hours. If she does, she will gain much insight into the environment from which the patient comes and to which he is likely to return.

Objectivity is something we stress, and not always with a clear realization that nurses are people. We expect nurses to give of themselves professionally, but remain emotionally untroubled. When we think about it, we are making great demands. Nursing any illness, and particularly severe illness, leaves us emotionally exhausted for we put so much of ourselves into the care of the patient. So it is with a psychiatric patient. The nurse uses her fund of tolerance, persuasion, and acceptance in helping these people back into emotional well-being. It is right, therefore, that we should permit the nurse to be a little impatient and a little discouraged at times. If we ask her to be accepting, we should expect her to feel warmly toward the patient who responds and improves under this acceptance. These reactions are within bounds, are everyday ones and are the results of, or the rewards for, the nurse's concentration on the needs of others. We should not, by our condemnation, try to eliminate them.

Conclusion

The mentally ill are found not only in the mental hospitals, but also in all other hospitals, in industry and in the fields of public health. For this reason, the need for knowledge of the principles of psychiatric nursing and the understanding of the mentally ill are of vital importance to all nurses.

FAMILY CENTRED NURSING

DORIS WEDDELL

The Cassel Hospital, Richmond, England, specializes in family centred nursing for patients whose symptoms of mental illness call for a period of hospitalization.

IN SPITE OF THE work of recent years by psychoanalysts, anthropologists, and sociologists, in elucidating the interrelationships of the family as they are seen in the psychic life of the individual, between members of a family, and between the family and society, the nurse has remained surprisingly guarded and suspicious in her relationship with the families of her patients. Until recently, even the pediatric nurse has tended to feel that parents were a necessary but often irritating adjunct to a child's admission to hospital. Only now is she beginning to recognize that a child's tie with his mother is important; that it is something to be cherished, rather than interfered with or broken. For nurses on a general hospital ward, the patient's family is often regarded as an added burden with which they must deal as best they can, rather than an essential part of the distressed situation that they must resolve. To the psychiatric nurse, the family of the long-term patient may hardly exist. The maternity nurse's need to possess mother and baby is well known. Visiting hours are too often considered as just part of the routine, an unwanted intrusion. They are seldom arranged to suit the needs of the patient and family. As far as I know there are few hospitals where the nursing task is shared with the family as members of the nursing team.

Miss Weddell is matron of The Cassel Hospital. She gave this address as a member of the panel participating in the nurses' section of the Third World Congress of Psychiatry held in Montreal during June, 1961.

Family Centred Care

The Cassel Hospital is an institution within the National Health Service of

the United Kingdom. It exists for the treatment of neuroses by psychological methods. There are three medical units, each one in charge of a consultant psychiatrist who is also a psychoanalyst. Each specialist has his own medical and nursing staff who work with 20 patients — men and women, married or single, and some families. Each unit consists of a dozen or so rooms opening off a central corridor or landing. There are bedrooms of varying sizes, a small kitchen, laundry and sitting room space. The unit functions somewhat as a large household. There are other sitting rooms for patients and a dining room that is shared by patients and staff, with the exception of the doctors. Each consultant is responsible for the care of his unit, keeping it in good repair, within a financial budget allocated each year. Patients are encouraged to work outside the hospital. The nursing staff help them to find work and also join with the patients in the household care of the unit.

The Nurse's Preparation

The nurse's interest in working with the family has grown out of a psychological understanding of the infant, child and adult's need of his family, rather than from any feeling of sentimentality or imposed procedure. The theoretical background of her training requires explanation. It occurs within a general, psychoanalytic framework, where the recognition of some manifestations of unconscious phantasy become part of her nursing skill with indivdual patients and groups of patients. The case assignment method of nursing is used. Each nurse has six to ten patients who are under the care of one or more of the doctors with whom she works. Traditional uniform is not worn. A blue summer dress and a grey winter suit make it possible for new patients to distinguish nursing staff from other members of the hospital community.

In 1948-49 Spitz's film, *Grief*, and Anna Freud and Bowlby's work with deprived children directed attention to what might be happening to children whose mothers were hospitalized. Melanie Klein's analysis of very young children demonstrated the possibility of understanding a child's feelings, phantasies, internal and external relationships as they were revealed in play. This helped the nursing staff to recognize the reality of the inner psychic life of the patient. They went to work with children in a day nursery in order to link observation with theory. This facilitated their understanding of the child that is still present in themselves and in their patients. Winnicott's idea that there is no such thing as an infant, that there can only be an infant-mother unit and that, for this unit to function satisfactorily, the father needs to "hold" support his wife as she "hold" supports the infant, made it easy for the nurse to see that on occasions her role would be to "hold" support the family unit of father, mother and child.

In attempting to understand the social scene of the hospital as it changed from day to day — its tensions, groupings, acting out of patients and staff, fluctuations of morale, and response to new occurrences, such as the admission to hospital of children with their mothers, husbands with their wives — the work of Brown, Lewin, Bion and Jacques have been used.

Perception of Role

Briefly, the nurse's perception of her role and the procedures that derive from this perception, are based on the formulation that she seeks to achieve a relationship with patients individually and as a group, in which she respects and works with the healthy part of the individual patient's personality. The nurse expects the patient to have a constellation of relationships, both in a family setting and at work. She will be concerned with these, seeking to ensure that hospitalization disrupts them as little as possible. She knows that upsets in the patient's internal world may be reflected in disturbed relationships around him. She uses her own response to the patient as an indication of feelings that the patient may be evoking in other people. She recognizes that the patient may, from time to time, invest her with feelings that belong to some member of the family in his psychic life, rather than to the kind of person that the nurse may be in the external world.

The nurse's role in relationship to

the family can be illustrated in her care of two types of patients — women who were ill before marriage, and whose illness now disturbs the whole family; women who have become ill as a result of a specific event, childbirth. I shall describe the nursing role in relation to each, illustrating the nurse's relationship with patients and their families in both situations and indicating the patients' capacity to nurse each other.

The nurse at the Cassel Hospital goes to the patient's home prior to admission, at a time arranged so that she can meet all of the family. With the specific types of patients just mentioned, she discusses the practical arrangements of admission. For instance, if a child is under one year, then its familiar cot, pram, toys and feeding utensils will accompany the family. For older children, the mother can decide what equipment she needs to make the change as easy as possible for herself and the children. The nurse's role is to help the wife to continue to care for the family as she would at home: Washing, ironing, preparing food, dressing the children, taking them for walks, putting them to bed.

The husband accompanies his wife and children to the hospital, and if he is not admitted, he is encouraged to visit whenever he can. He will often help his wife to put the children to bed, and perhaps go out with her afterwards. There is a good deal of mutual support and cooperation between patients in looking after each other's children. Sometimes, husbands will get together to decorate a room, or to mend some of the children's toys. A husband may be having treatment in his own right or with his wife. Some husbands may show signs of becoming dependent on the nurse. In such cases, the nurse usually sees the husband and wife together. She tries not to get involved in being the exclusive confidante of one or the other. She interferes as little as possible with the normal family situation, but she is available if there is any difficulty. It has been known for patients to fight each other, for husbands to walk out fed up with their wives, or vice versa. In these situations, the nurse usually talks over the trouble with the people concerned. Sometimes, other patients will act as arbiters. The therapist may discuss the matter in the treatment situation, but will not be involved in actual disturbances, as a general rule. The nurses will also discuss any areas of disagreement among themselves that may be reflected in the patients' upsets.

The Child's Position

The nurse is interested, quite naturally, in the child's development, and the effect upon him of coming into hospital. He often reflects his mother's anxiety. The nurse sees, as her role, the need to deal with the *mother's* problem rather than to do anything for the child herself. She will try to understand the difficulty that the mother may be having with the child, her husband, another patient, her therapist, or with the nurse herself. She will not necessarily do anything to solve the problem but, by verbalizing what she thinks the mother is feeling, she may help her to maintain her relationships in the external world, while the therapist and the patient investigate the upset in the latter's inner world.

Children will miss their fathers, if they are not able to see them as frequently as they would have done at home. Sometimes other men, staff or patients, will be regarded as foster uncles by the children.

Patients and Problems

Whenever possible, patients go home for the weekend. As a general rule no treatment sessions are carried out on Saturdays or Sundays. Particular demands on the nurse's understanding are sometimes made by the patients who remain in hospital at such times.

> One weekend a mother said that her child, Nancy, aged three, was ill. She wanted the local doctor, who looks after the physical state of the children, to be asked to come at once. The nurse knew that the patient's husband was not coming to see his wife who was pregnant. Neither one wanted the child. Nancy sometimes went home to her father when he did not come to the hospital. The nurse had to decide if this was the wife's anxiety about her husband not coming to visit, or a transference reaction as a result of her therapist being away. Was the child's illness simply

distress at missing her father, or did she have an infection?

The mother was sure that Nancy was about to have a serious ear condition, that she had a lump behind her ear. Nancy did have a slight temperature and was fretful and unhappy. Nothing seemed to satisfy her. The local doctor was called for, though not anxious herself, the nurse felt that he would be something of a substitute for the absent husband and therapist to the patient, and father to the child. Next day, both the mother and child were better although no treatment had been prescribed. Nancy, however, was seen later sitting in a chair with a big red ball pressed against her tummy, talking to it, patting it and then throwing it away. Nancy's own anxiety about her mother's pregnancy was made clear. It also turned out that the mother was very much concerned at that time with ideas of having the baby adopted.

If this incident had not occurred at a weekend, it might have been felt as more useful, from the point of view of treatment, for the nurse to have helped the mother to contain her anxiety until she next saw her therapist. How to maintain a friendly concern for the patient without becoming a readily available substitute for the therapist is part of the nurse's skill. This situation can be complicated by the needs of the child in his own right and his ways of dealing with his mother, as well as the use she may be making of him.

At present we have no facilities for treating children, although some of them are obviously disturbed. There is a play group for children over two years of age once a day. It lasts an hour and the children have an opportunity to express themselves with materials such as paint, plasticine, water and sand. From the few observations made to date, it would seem that the mother's wishes and attitudes are reflected, as well as the child's current anxieties and phantasies. The children seem to pick up and express in their play, problems that are preoccupying the community as a whole. Gluck and Wren have written of some aspects of the psychological treatment of these mothers and their children in hospital.

For those patients whose illness is the result of a particular event — childbirth — the nurse's role is somewhat different. In this instance, the family breaks up very quickly. By the time the letter from the referring doctor has reached us and the nurse has reached the patient's home, the family may have split. The husband may be with his parents and the wife with her mother, while the children are being looked after by someone else, often the local welfare agency. The first task of the nurse is to gather the family together so that she can discuss the prospect of admission and offer treatment. It is usually essential for the husband to come into the hospital with his wife. Not only is he needed in the therapeutic team, but he may become the chief source of nursing care for his wife. In this case the nurse's task is to support and reassure him in this role which tends to give him satisfaction, relieves some of his jealousy of his wife's mothering capacity, but arouses guilt insofar as he feels that he is usurping a role that is usually assigned to women.

One evening a call came from the local maternity hospital. A patient in the lying-in ward, seven days postpartum, was very depressed and confused. Could she be admitted? The nurse went to the maternity hospital. She saw that the patient had regressed to a point that she could hardly do anything for herself. She needed her husband with her all of the time. After some difficulty he was persuaded to take a fortnight's holiday and to come with his wife into hospital.

During the next few days he virtually became a mother to her. She behaved as if she was the baby — clinging to him, having to be fed and washed. Nevertheless, with the husband's support and that of the nurse, this very ill woman managed to feed and care for her child. Meanwhile, in her psychotherapeutic interview, the confusion between herself and the baby, among other things, was examined. Gradually she became less dependent on her husband. He was able to return to work and she could go home, though she continued with treatment for some time.

It is important for the nurse to understand how she may be *experienced* by these patients some of whose difficulties arise through their having

an extremely envious internal mother who has to be placated through suffering and failure of the individual's mothering capacity. It is obvious that the unmarried nurse's envy of the patient's childbearing capacity, may easily lead her into collusion with the patient. They may even agree together that the patient is not a good mother, and that her children would be better looked after by someone else. The patient's wish to be free from ties of mothering, to become single again, can sometimes lead to a useful discussion between nurse and patient in relation to their envy of each other.

Patients Nurse Patients

Other patients who may not be quite so disoriented but who have destructive phantasies and impulses towards their children, present a different problem to the nurse. Her task is to help the mothers to nurse each other. We have found that with such patients something quite dramatic happens on admission before psychotherapy has had time to produce such a change. The young woman who, a few hours before, could not contemplate *holding* the baby, to say nothing of feeding or bathing him, will find herself doing just those things. She will be just as frightened as before that she will drown the baby, poison him, or throw him out of the window. However, she sees other mothers who have these same fears looking after their infants, so with their support and that of her husband and the nurse, she begins to try her hand. The nurse will often be in the bathroom while the mother bathes the baby, if the patient feels safer that way. She may help the mother, but as a rule will not actually do it for her. Similarly, she may sit with the mother, when she is feeding the baby, if desired. When the mother is alone at night and is anxious about her destructive impulses it is usual for another patient to share a room with her. Other patients will look after the baby when the mother is having a bad day. These matters are discussed at meetings between nursing staff and patients. A new patient who is particularly disturbed, frequently finds it helpful to share her fears with other patients and the nursing staff, so that the difficulties that each may have about what the other will do, can be brought out in the open. Anxieties seem to be lessened as a result.

Observing the Patient

Listening to and observing the mother and baby together will help the nurse to have some idea of what the baby may mean to the mother. When the baby is fretful and difficult to satisfy or very aggressive, scratching or biting his mother, she may feel that she cannot stand him at the moment. It is not difficult for the nurse to guess that the baby is felt as the greedy, destructive part of the mother herself, the part that she cannot understand just then. The baby may also seem to be something of her husband in whom the wife feels she is disappointed and wishes to punish. Sometimes it may be clear that the baby is almost like a doll. The mother feels that she should be able to do what she likes with it. Or, it may seem to be just a dirty, messy thing that has come out of her body. How can she comfort and love something like that? Understanding of this order helps the nurse to assess the risk to the child from his mother's destructive impulses, and to the mother from her suicidal wishes.

Sharing and Understanding

The capacity of the mothers to tolerate and understand such impulses in each other, has proved to be an important factor in the nursing care of these patients. With the help of their doctors the patients gain some understanding of the sources of these impulses and fears. By discussing their difficulties with the nursing staff and other patients, they feel less outcast. It can be seen, however, that nursing of this order is not easy to achieve or maintain. It makes great demands on the nurse and on the therapist.

The medical and nursing staff gain support by sharing together, in meetings of various kinds, something of the anxiety that such patients may arouse in each of them. The nurse, through recognizing some of the sources of her own love, hate, and rivalry and of the envious, destructive, possessive and restorative impulses inside herself in relation to her own family and to the hospital, can understand something of what the pa-

tient is experiencing. This helps her to respond appropriately.

Conclusion

This has been a description of the nurse's role in a situation where patients have been considered as individuals in a family unit and who have been enabled to function as such. In primitive countries, a thesis such as this would not be necessary. No one would go to hospital unless some close member of his family accompanied him. Many psychological, sociological and physical factors have contributed to the situation in Western hospitals, where the patient may be almost dispossessed of his family. It may be that, with further study of individual psychic experiences, the role of the family in health as well as in illness will become clearer.

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In the Good Old Days

(*The Canadian Nurse* — October, 1921)

A (private) nurse is entitled to five hours off duty if she is doing nineteen hours duty. Let her take stated hours, and be back on duty when she has promised to . . .

* * *

A survey was made by the Canadian Red Cross Society at the request of the Canadian National Association of Trained Nurses and the Canadian Association of Nursing Education to determine the extent, degree, causes and possible remedies for the apparent shortage of pupil nurses . . . The cause most frequently assigned was "the attractiveness of other occupations." The average number of student nurses was one to every 3.5 beds. On this basis it was estimated that there were nearly 9,000 young women in the nurse training schools of Canada.

* * *

(Educational) standards are, or should be, definite, and it is superfluous to point out that the steadily increasing complexity of the technicalities of modern scientific nursing make it impossible to instruct adequately a pupil of inferior general education.

* * *

The folowing were included in a questionnaire used to determine possible reasons for a shortage of student nurses. The answers obtained are indicated.

	Yes	*No*
Other occupations are more attractive	53	20
The hours of duty are too long	50	26
The living conditions are uncomfortable	46	24
The lack of salary during training	39	31
The nursing profession is becoming commercialized	40	18
The food is poor or monotonous	37	31
There is too much menial work	34	36
The vacation is inadequate	27	36
Three years is too long to spend in training	7	79

The Public Health Nurse and the Mentally Ill

RUTH GILBERT, M.A.

Mentally ill patients are being enabled to move with much more freedom between care in the mental hospital and care in other parts of the community such as their own homes, foster homes, day care centres, psychiatric units in general hospitals and the like.

THE MENTAL patient and his family or those who stand in lieu of family to him, are becoming part of the responsibility of all nurses. Some of you may know George W. Albee's book, *Mental Health Manpower Trends*.[1] It is one of the studies included in the work of the Joint Commission on Mental Illness and Health in the United States. Dr. Albee's report was most discouraging. If he had been writing even a year later perhaps he could have discussed the *redistribution* of effort among professionals within and outside of the mental hospital. Relating this to nursing, if this more inclusive range of nurses is well prepared and functions well, we may not need the impossibly large number of psychiatric nurses that he saw as essential, though we need more than are now available.

I would like to review with you in broad terms and perhaps in an oversimplified way some of the areas of knowledge and skill that public health nurses use and wish to develop further as part of the redistribution picture.

1. We have, or must acquire a really useful knowledge of local and regional resources for the diagnosis, care and treatment of the mentally ill of all ages.

So often we *think* we know how to use such resources and they *think* they know how to use us. Mutual discouragement or even distrust develops when this is found not to be the case. Each professional group may consider the other professionally naive — than which there is no more troubling condemnation. Sometimes *staff* nurses do know very well how to use resources appropriately. They may have worked out good individual relationships with other agencies only to be apparently thwarted by legal regulations limiting exchange of information about patients, or by the general lack of workable inter-agency policy. Questions raised at an interdisciplinary conference included the following:

> Should the public health nurse's point of contact with the hospital be the social service department, the nurse on the ward, or the psychiatrist?[2]

Some of you may have progressed far beyond the need to raise such a question. However, it is an example of the kind of communication problem that must be considered at both policy and operational levels and at local as well as provincial levels if public health nurses are to fulfil their responsibility for work with the mentally ill.

2. We need more familiarity with pathology, at least at the descriptive level.

(a) We need to feel reasonably sure of our ability to recognize behavior on the part of any individual that indicates that he is very disturbed or actually mentally ill. It may be true that we have more ability to recognize such symptoms than we think we have. Public health nurses always have found the mentally ill among their patients. Until recently, however, the reluctance of many public health nursing agencies, at least in the United States, to include such patients as part of the nurse's regular case load, unless obvious "physical" illness also was present, made

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Miss Gilbert is professor of nursing education, Teachers College, Columbia University. She gave this paper as a panel member on "The Impact of Social Change on Mental Health and Psychiatric Nursing," at the Third World Congress of Psychiatry, Montreal, June, 1961.

work with them seem somewhat outside the skills that the public health nurse was supposed to have. Now, other professionals, public health agencies, and the nurses themselves expect the latter to recognize mental illness when they see it and to be able to offer appropriate help. I think it can be stated that public health nurses can learn the symptoms of mental illness and keep themselves up-to-date with new information of that kind by well-planned in-service educational programs. In a field of work where new information, rectification and important "hunches" are constantly being made available, we shall all need in-service education from time to time, even if we have had a good grounding in this material on an academic level or otherwise.

(b) We are being called upon to use and to develop our understanding of pathology in the interaction of those people close to the patient — in his home, school, place of work. This includes the ways in which such persons interact with the patient and how they interact among themselves, thus forming part of the patient's environment.

These, and other situational factors, call for particular inclusion and assessment by the nurse. She has always "known her community well." Now, she must learn from the social psychiatrist and others how trends in family and community life in general, and in a given community in particular, may have a bearing on her patient. To some extent this is a reorganization and a consciously focused use of information and understanding that the nurse already has but may not have recognized as highly pertinent.

> A nurse was dismayed that a patient was being discharged from a mental hospital to his home. She said, "But it was his home that made him that way!" Then she said, "No! I'll have to think more about the reasons for the difficulties of *all* in that family."

Sometimes nurses experience a noticeable change in the way they look at the behavior of others as a result of greater concentration on such symptomatology and interaction. On the one hand, the nurse may find that she sees not only grave symptoms of illness in the behavior of some persons, but that she sees bits and pieces of such behavior in many persons, including herself. So it may seem that "everybody" is quite sick, or on the way to being so. Feelings of this kind may be part of the reason that relatively few nurses have specialized in psychiatric nursing. On the other hand, when the public health nurse participates in a so-called "follow-up" program for discharged or paroled patients, or works in a community that supports such resources as day care centres, she sees that even people who are quite ill mentally can make their way relatively well in the community. This may lead to an acceptance of a much wider range of behavior as within the "normal" range.

Either way, as the nurse struggles with her concept of what type of behavior is sick or somewhat sick, well or relatively well, her previous ideas as to acceptable behavior may be severely shaken up. She must think about each patient and his situation in a new light. One might risk the comment that this is good for the nurse. And what is good for her is good for society.

3. I would like to mention a fear that some of us have — hopefully, an unfounded fear. It would be unfortunate if the increased opportunity to work with the mentally ill, including special financial support for such programs, diverted us from our ongoing generalized public health nursing programs.

We might all agree that our increased effort toward diagnosis and care of the mentally ill should become a part of *generalized* programs immediately, developing partially from them and feeding back into them. Not only are these generalized programs essential as a service but an increasing number of agencies and their staffs might well take part in epidemiological community studies that attempt to find out more about cause and effect in mental illness. Such studies are assisted, not only by the ready access that the public health nurse has to many homes, but by the number and variety of them, the range of situations found and the services given under the generalized program.

As epidemiological studies continue, surely we can hope that they will reveal more fully that which is health-giving as well as that which is destructive. When such results reach us, we can be more sure of the usefulness of the pre-

ventive work that the public health nurse tries consistently to do.

An important matter remains to be mentioned, *the nurse's "use of self"* with patients and others — in this instance, primarily the mental patient and his family. It is perhaps true that the behavior of the patient may not cause us as much anxiety as the thought that we may somehow fail him because of lack of knowledge and skill. We may feel this way even though we have tried to learn. It is not necessarily reassuring to remember that no one knows all about mental patients.

We are told rather frequently that we are, or should be, *sensitive* to our patients and their situations. Dr. Martha Clifford, Connecticut Department of Health, speaks of the public health nurse's influence as being so "direct" and so "sensitive."[2] Dr. Ida Gelber says, "The functions assigned to the public health nurse imply a knowledge of personality structure, and the dynamics of human behavior; of modern concepts of mental illness and its treatment; and a *sensitivity* that will make this knowledge useful in understanding and helping these patients."[6]

The implication is that this sensitivity enables us to see, hear and assess accurately, and to respond to the patient and his family in a way that is helpful in a specific situation. We wish to do this consciously, intentionally as well as intuitively. People in the helping professions are struggling toward this goal.

At the close of a semester in the college where I teach, a very capable, intelligent student handed in a term paper on "Anxiety — The Role of the Nurse in Helping Anxious Patients." It was well organized, well written and useful up to a point. But nowhere did it say anything about the necessity for the nurse to have recognized and worked through some of her own fears and anxieties about the important events of life that come in such forms as birth, love, work, death and daily interaction with all kinds of people. We, as nurses, are always re-examining the feelings and attitudes that result from the events and relationships of our own lives. We do this in order that we can remain steady and able to think when we meet the anxieties of others, so that we can attempt to understand their problems without confusing them with our own.

Mary Cloud Bean, writing in *1908* on "Psychology and Nursing," lamented that American medicine and nursing seemed to be lagging behind the European school. She noted that

> In spite of the fact that considerable information is getting about on "how to nurse" a nervous patient, there is still a lack of knowing why such and such a practice is necessary. Blind routine can never give the results of informed activity . . . nurses must somehow get possession of those facts of mind and mind-working on which psychotherapy rests . . . She (the nurse) will also be helped in her own mental life to a degree that amazes her if she has not heretofore thought deeply on inner things.[7]

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Mental Health and Children

FRANK DUNSWORTH, M.D.

A physician's impressions of what nurses can, as well as what nurses cannot contribute to the mental health of children.

IT SEEMS TO ME that the greatest value of the nurse in this field lies in possible prevention and early detection of emotional problems in children and the early referral of disturbed children for treatment. The nurse can offer support to the patient and the family during the course of treatment and finally, can contribute through her continued interest in the follow-up care of the patient after treatment.

My basic philosophy is that, generally speaking, a great number of emotional conditions are preventable. In particular, in the last 12 years it has become increasingly obvious to me that the overwhelming percentage of cases of emotionally disturbed children that I have seen, both privately and at the Child Guidance Clinic, are basically reacting to disturbances about them and exhibiting their own specific response to these disturbances.

I feel that the nurse could be of great value because of her early contacts with the family. Nurses frequently see a mother throughout her pregnancy. They see many youngsters in well baby clinics. They can often gain, over a period of time, a good insight into the particular mother's functioning and the handling of a child. Nurses are taken into the confidence of the patients many times and can learn a great deal about the family and any conflicts or disagreements within it.

It is my impression that with so many diseases now under better control, the public health nurse is able to take the time to help in promoting mental health. Previously she may have had the interest but rarely the time.

Mental Conditions in Children

Clinically, three categories of mental illness are seen most frequently. They are relatively specific and almost invariably associated with a given set of attitudes on the part of the mother and family. Though mixtures of these categories can occur, basically the syndromes are easy to recognize and fairly clear cut.

Category One

The first category of disturbances in children occurs most often in the preschool or early school age. It is what we call a *habit disorder*. This refers to a prolongation of immature, infantile habits such as bed-wetting, thumb sucking, nail biting, dependency reactions and childish behavior. We find that immaturity reactions in the children are produced by immature mothers. Immaturity is very hard to define because it is so relative. But generally speaking, one can get the impression, after even a relatively brief contact, that such and such a mother is very childish, dependent and unsure of herself. Her whole attitude towards the world is one of bewilderment when she has been emotionally overwhelmed by the responsibility of caring for a baby that biology has somewhat unwisely permitted to appear.

It is in this category that most help can be offered by the nurse. Theoretically, the detection of a case of habit disorder in the child should be possible even before the actual reaction appears. Immature persons are usually easy to recognize. If they happen to be female and married, they are likely to have children. If they do have children, the offspring are likely to show what we call "a habit disorder." Just to make things more complicated, immature women tend to attract immature men. The prevention of the transmission to the next generation of these immature attitudes is one of the greatest challenges in mental health for the nursing profession.

Nurses will encounter this type of mother during her pregnancy. Assistance should be given then. The nurse can help to dispel ignorance and thus

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Dr. Dunsworth presented this paper at a conference held at Dalhousie University School of Nursing, Halifax, N.S.

prevent fears and instil a positive, mature approach to life and its problems. For many of these immature women, their whole attitude towards having a baby may be a very mixed one. There is the happiness of a little girl with a new doll, tinged with the regret that now they can no longer rely on their mothers and that soon they will have to go through what they have frequently heard was a most harrowing experience — childbirth. Forward steps have been taken through promotion of natural childbirth. Results have come far beyond simply helping the mother face labor and go through it in a healthier way. There is a certain amount of emotional support that these mothers gain from meeting with other mothers-to-be. Above all, they are supported by the relatively frequent contact with doctors and nurses who are available to answer questions and to help them to face their responsibilities. Natural childbirth is partially group therapy and as such is very valuable.

The attitude of disparagement and criticism sometimes shown towards these immature women is very unlikely to assist them. If we look upon them as scared children who truly are afraid, we can help them most. They should be encouraged to talk about their fears. They should be given time to ask questions. They usually have been brought up in a psychologically unhealthy way and unless one can be kindly with them, they will attempt to bottle up their fears and unfortunately will be overwhelmed by them eventually.

Very early contacts are important, but clinically the next stage is tremendously important too. At this point I feel that I must speak out very strongly against some of the present attitudes towards infant care. It is only when a nurse becomes a mother herself that she begins to realize that the highly complicated ritual of preparation of food and baby care is utterly unrealistic in our modern world. If the new mother followed faithfully and compulsively all the things that she was supposed to do, she would have approximately two two-hour periods free for herself, her family and the rest of the household including her husband. This would be between 1:00 and 3:00 A.M. and 4:00 and 6:00 A.M. As I see it, the rest of the day would be spent in boiling bottles, sterilizing nipples, squeezing orange juice, changing diapers, washing linen, bathing the baby, etc., etc., ad infinitum.

Fortunately, most mothers, after the first baby, find that much of this compulsive ritual is possible only in a highly organized hospital. They usually become much more relaxed for the good of all concerned. Unfortunately, it is the first child who frequently turns out to have a habit disorder. Picture the young, immature mother with her first baby. She is afraid and she is ignorant. We, in medicine and nursing, have made her more afraid. Frankly, there are so many articles on child rearing, all somewhat different in their approach, that it is amazing that the poor modern mother is not more disturbed. In the average daily paper and in the average women's magazine there are at least three articles per issue on child care. Fortunately, after the first baby, most mothers stop reading them. Again, it is usually the first baby that shows habit disorders. Just to make things more complicated for the immature mother, grandmother may be there to treat her like a little girl and that, of course, keeps her like one.

So much of the treatment of the habit disorder is on the basis of good common sense which, unfortunately, is far from common. The best treatment that can be offered for this type of mother is to give her confidence in her own judgment, plus factual information when it is required. It must be remembered that *opinions are only opinions*. The opinion of the nurse may not be any better than that of the mother, but factual information may be very helpful. I urge such mothers to try to use their own judgment and not to let others interfere. Though they might be helped by professional information, the specific attitudes used in bringing up their children are going to be their own. They should take a strong stand in discouraging interference from well-meaning, but meddling relatives.

I also urge the immature mother to stop reading all sorts of medical articles on child care. I suggest literature by *one* authority and discourage anything else.

Of all the groups in child psychiatry, I feel that this is the one that

can be helped most effectively by the nurse. The results in prevention will be very worthwhile.

Category Two

The next two groups are less likely to be helped by the nurse. They represent the two commonest sets of reactions that we see at the Child Guidance Clinic. They occur anywhere from the age of seven on but the peak seems to be somewhere between 10 and 14. The first is the very common neurotic reactions of childhood. I do not mean the temporary, relatively-easily-resolved fears that many children show during their growing up. I am referring to the initial appearance of deep-seated neurotic reactions that will probably go on to maladjustment in later life. We find that most of these neurotic reactions are related to over-protective, neurotic parents, also invariably the mother. I do not feel that the average nurse is competent to carry out psychotherapy. The best that she can do is to recognize that the mother is suffering from an appreciable neurotic illness and that she should have professional help. At times treatment is not feasible but it should be attempted, even if it is only one consultation.

Since we know that neurotic parents contribute markedly to the production of neurotic reactions in their children and if we cannot change or modify the parents, the least we can do is to try, in a subtle way, to take steps so that the child will not be exposed to these attitudes. This means encouraging the mother to have interests away from the child and the child to have interests away from the mother. I can remember one very neurotic, over-solicitous mother whom we could not modify. She was well on the way to producing a very severe neurosis in her daughter. Then, more by good luck than good management, we were able to get her involved in so many women's organizations that she let the apron strings go. The child made a very appreciable improvement because she was associated with the healthier influences of youth organizations. Unfortunately, this is the exception rather than the rule. We find that most neurotic parents will not permit their children to be independent. They are tied to them so closely by mixed feelings of guilt and resentment that, psychologically, they cannot permit them to be independent. Neurotic reactions are usually too much for the nurse to handle with simple methods.

Category Three

The third group is made up of those with what we call the conduct disorders. These are the youngsters who show many aggressive attitudes. These may be against home, school or society. A high proportion of these individuals are going to go on to antisocial acts and then be dubbed, "juvenile delinquents." They come from any level of society. In the upper level the child is usually sent away to special or private schools and, unwittingly, by being removed from an atmosphere of rejection and hostility, he does not show as much reactive frustration. The history shows a child who is perhaps a bit more aggressive than normal and who is exposed to fighting or aggressiveness between the parents or overt rejection, that is, open rejection of the child by the parents.

Our big regret in this category, as well as in the neurotic reactions, is that we see the children so late. All of our studies indicate that, in the conduct disorders, the symptoms have been coming on for a minimum of two years before we see the patient. In some cases symptoms have been evident for 10 years. If there were earlier recognition of neurotic reactions and conduct disorders, and earlier referrals for treatment from nurses, school teachers, family physicians, the courts, etc., we feel that we could offer much better results.

A word of warning in regard to the latter two categories is in order. We have found that the most important evaluation that we can carry out during the early visits is, "What is the motivation of the parents? Unfortunately, in many of the neurotic reactions, the parents are so emotionally involved and so emotionally disturbed that they will not accept any offer of help because it may upset them. They are content to continue with their present methods and will not take the stand of "fighting against" their neurosis. In the conduct disorders, we usually find a great deal of rejection of the child. A high proportion of the

parents bring their children to us, hoping that in some socially acceptable way we will get rid of them. They will go so far as to say, "We will send them, but don't expect us to come." We have to point out in all such instances that unless they feel that there is an appreciable problem and unless they are willing to do all within their power to solve it, there is nothing that we can offer.

The Nurse's Role

These three categories comprise by far the commonest mental conditions that we see in children. It is in relation to habit disorder that the nurse can offer so much help in prevention. She can also contribute a great deal by encouraging early referral of the cases that cannot be treated by the doctor in general practice or by some other agency. *If the referral is early enough, and if the motivation of the parents is good, the prognosis is much better.*

The nurse can assist materially through her contact with the families while treatment is going on. At times, much criticism has been directed towards the Guidance Clinic particularly by the parents of youngsters who have a neurotic reaction. Basically, these youngsters are fearful, inhibited and repressed. They have rarely, honestly expressed themselves. They have always been intensely concerned about what other people thought, especially their neurotic parents. Naturally in guiding them to be "average children," you will have to expect them to be mischievous. It is at this stage that the help of the nurse to encourage the parents to continue treatment is of great value. The previously very shy, sensitive child will start to show more independence. His language may change and the parents, who have never been honest in their own feelings, will be somewhat shocked. This shy, sensitive youngster, instead of being afraid to speak up at school or deal with other children, will probably come home with nasty remarks on his report card from the teacher who had previously considered him such a "good boy." He may appear with a torn shirt after a scrap with the local bully whom, up until now, he has been afraid to tackle. These are all signs of improvement. It means that the treatment is beginning to work.

In the conduct disorders there is usually so much hostility in the parents that hostility towards those giving treatment will have to be expected. Sometimes the parents bitterly resent the fact that the youngster seems to be getting along better. A high proportion of them break off treatment. Others will criticize the social worker who is trying to point out to them what steps they could take in handling not only their own, but their children's problems. Any encouragement that can be offered to these parents by the public health nurse or any interpretation given to the school authorities has great value. Contacts that are concurrent with therapy should always be reinforced by frequent contact with the persons responsible for the program of treatment. The closer the contact, the better the results.

The Constellation

Both medicine and nursing have an unfortunate background. We have been brought up to treat a diseased organ or a specific disease rather than the person. The trend is fortunately reversing but it has not done so completely as yet. We still refer to the ulcer case or the case of pneumonia or coronary thrombosis or cancer. We do not treat *conditions*, we treat the *patient* who happens to have one of them. The patient has many things about him besides the particular condition for which we have seen him, in somewhat unsplendid isolation, in hospital. He has, for example, a family, a job, friends, social, cultural, economic and religious backgrounds. Every patient is a separate person. It is on the understanding of this constellation that the main approach in child psychiatry should be based.

Unfortunately many referrals are still made on the premise that if the physical examination is negative, the condition must be psychiatric. How often too, have cases been referred simply because they were "problem" (unspecified) as if all problems should be sent to a psychiatrist. We still see the situation of a patient with what he considers very legitimate complaints, being examined and told that there is

"nothing wrong" whereas the doctor should have said, "I can find nothing physical to explain such and such a condition; there must be some explanation and we will have to look and see what it is." Though I realize that the physical approach to the body is tremendously important, there are so many other parts to the total constellation that we must consider, that I am omitting the physical conditions that tend to produce emotional problems in children. Incidentally, they are very few.

There are at least seven other areas for your consideration. Within the patient we must consider his intellectual capacity. This is not simply a matter of I.Q. Intelligence quotient is a frequently used and almost completely abused term. It is a comparison of how an individual performs on certain given tests. Though it is relatively accurate for performance at a given time, it does not and was never meant to decide everything from adoption to marriage, to vocation, to work, and value in the community. Within the intellectual capacities there must constantly be kept in mind the fact that there are gifted as well as retarded children. A good school system is a necessity in helping both gifted and retarded children to make a proper adjustment to future life. Reading difficulties and speech difficulties should fall within the constellation and must always be considered. Emotional factors within the child have been mentioned but, in child psychiatry, we find that understanding the family and the family attitudes is of tremendous importance. Though at times we may feel very disappointed or even angry at poor family attitudes, whether we like it or not, the child usually functions within a family. Ideally, this is where a child should be brought up but there should be much more logic used in the placement of children for adoption and in foster homes than would seem to be the case in many instances. I feel that nurses should have some opinions on what constitutes proper adoption and foster homes. This is not only a matter of whether the family has nice quarters, indoor facilities and adequate income, but should include the total emotional setting.

Another area that must be considered seriously is the attitude of the neighborhood and the social and the cultural aspects about the child. We know that if the general neighborhood attitudes are delinquent, the child is more likely to get into trouble with the law. If the attitude of society is one of minor crimes, smart business practices that are immoral if not exactly illegal, these things will contribute much in producing an antisocial outlook in the child. Some of the cultural backgrounds from which our children come, are likely to cause difficulties in their adjustments. If the attitude of the particular small culture from which the child comes is unhealthy, we are up against a major problem.

One of the greatest influences in the child's life, after the family, is the school. Any of you who are involved in school nursing should do all in your power to strengthen this particular segment of influence in the life of the child. We hear criticisms of teachers who ask for adequate salaries, just as we hear criticisms of nurses when they ask for adequate salaries. It is more important to emphasize the service that is offered to the child rather than what it does to the pocketbook. One of our greatest untapped natural resources is our youth. A high proportion of this natural resource is being lost. We have a large number of under-achieving children and thus we will have under-achieving adults. If the trend continues, the outlook for the future is poor. Anything the nurse can do to help the school produce a happier, healthier and thus more productive child will be of great value.

Finally, we must consider religious attitudes. It has become smart in this century to be very critical of any religious teaching. We have everything from the frank atheistic approach to the mixed-up existentialists, "beatniks" and fundamentalist religions. Speaking as a psychiatrist only, I feel that a standard of behavior based on the laws of God and man are of great help in helping to produce psychic stability.

Each man the architect of his own fate. — APPIUS CAECUS

The Archives Room

BETH DALE

A description of the historical collection at The Toronto Western Hospital.

THE DEPARTMENT OF ARCHIVES of The Toronto Western Hospital was founded in 1954 as a three-way project sponsored by the hospital, the nurses' Alumnae Association and the Women's Board. The material is housed in a room of the nurses' residence. It is a room of quiet, warm decor. Among those instrumental in gathering the material for the archives were:

1. Miss Beatrice Ellis, superintendent of nurses, for 25 years.
2. The late Mr. A. J. Swanson, who was superintendent of the hospital for many years.
3. Miss Marjorie Agnew, an obstetrical supervisor, who continues to give unstintingly of herself and her time to this project.
4. The late Miss Gwladwen Jones.

The Archives Room will ever remain a tribute to Miss Jones. Throughout her 30 years on the staff, she revealed nursing as an art, wherein each patient's need evokes each nurse's greatest skill and sympathy. Keenly interested in the Archives Collection, Miss Jones had the courage to closely examine the past, the vision to consider the future prayerfully, and the wisdom to synthesize the two while devotedly living the day at hand.

On entering the Archives Room, one is greeted by a mahogany desk on which rests a book for the signatures of visitors. On the shelves under this desk are several albums containing names and photographs of the School's graduates. Above it, hangs a water color of Florence Nightingale. On an adjacent wall are framed some of her famous nurses' notes and letters, written prior to her departure for Crimea.

In the middle of the room are two library tables on which are albums with photographs of both Toronto Western Hospital, and Grace Hospital, which closed its doors in 1936 when its patients were moved to the Western Hospital.

Along two other walls are glass-covered, dustproof cabinets with drawers beneath. In

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Beth Dale is the nom de plume of a well-known graduate of Toronto Western Hospital.

A sanctuary for valuable relics

one of these drawers are the photographs and books belonging to Dr. Augusta Stowe Gullen, the first woman to receive a medical degree from a Canadian university. Dr. Gullen married one of the original twelve physicians on the staff of this hospital. She herself was on the staff, organized the Women's Board, was a founder of the National Council of Women, a leader in the suffrage movement, and one of the first women trustees of the Toronto Public School Board.

One cabinet contains two dolls dressed in the style of the original uniforms of both Toronto Western and Grace Hospitals. From the Western uniform hangs a pin-ball holding several large pins originally used by the nurse to secure several layers of blankets as a mattress. Another part of this miniature uniform is a small fan of celluloid leaves — one for each day of the week — on which the nurse wrote her day's duties, and later washed them off.

Carefully mounted in scrap-books, between layers of pliofilm, are photographs, clippings and interesting directives such as this one from a 1902 newspaper:

> Surgeons are requested to furnish their own rubber gloves when operating on private or semi-private patients.

In another cabinet is a film, "Through The Years," made by Dr. A. I. Willinsky, depicting the life of a student nurse.

Along the east wall are cases containing interesting donations from the Women's Board.

Each item has been carefully indexed in duplicate — one copy kept in the room, the other retained by a member of the Archives Committee. This committee consists of four members who are responsible for maintaining interest in, and collecting pertinent articles for the Archives.

Here is a quiet sanctuary where one joins hands with those who have walked an earlier path in the history of nursing and medicine, and where one is strengthened to turn to the future with a greater sense of responsibility and honor.

Is this publication in your library? The Canadian Red Cross Society is searching for a set of a monthly pamphlet published during World War II entitled "The Prisoner of War — Canadian Edition." The pamphlet was originally published in England and distributed by the Red Cross to the next-of-kin of prisoners-of-war. From 1942 until the end of the war, it was published in Canada. Not even one complete set of the publication has survived and it is wanted by the Canadian Red Cross Society, the National Library and the Department of National Defense. If you have a set or some individual copies, it would be appreciated if you would send them to the Canadian Red Cross Society, 95 Wellesley Street East, Toronto 5, or to your nearest Red Cross Branch for forwarding.

Book Reviews

The Art of Clinical Instruction by Lillian A. Sholtis and Jane Sherburn Bragdon. 217 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 1961. Price $5.75.
Reviewed by Sister Muriel, Clinical Instructor, St. Mary's Hospital, Montreal.

Clinical instructors often feel "at sea" without a map to show them which route to take to ensure their ship's arrival at its destination. The authors of this book, full of empathy for these unsure travellers, have chartered the sea of educational opportunities on hospital wards. They have succeeded very well in showing that there are many safe and sound approaches to the same goal. The beginning instructor will find support and the experienced instructor rejuvenation in considering what the authors have to say about the teacher of medical and surgical nursing, her responsibilities and the characteristics that she should have to enable her to meet the needs of students.

This book gives very clear and definite suggestions for organizing a course in medical and surgical nursing, using various methods such as the problems approach and the age-group approach. The teacher should certainly be stimulated by this presentation to study the different approaches, to compare them and to select the one best suited to her clinical area and to her own interests. Emphasis is placed on planning content around all the needs of the patient and on minimizing repetition.

Recognizing the great importance of encouraging nurses to become sensitive to the feelings and reactions of others, considerable stress is put on effective communications and the art of working harmoniously with various levels of personnel. Along with this, there is a discussion of methods of patient education with a detailed guide for teaching a hemiplegic patient.

About half the book is taken up with sample forms, comparative charts, course outlines, nursing care plans, clinic and study guides for teaching the nursing care of medical and surgical patients. It is probable that clinical instructors in the operating room and the outpatient department will find this book particularly useful because of the suggestions related to their specific areas.

Readers of this book cannot help but be impressed with the vastness of the responsibility carried by clinical instructors. The authors have given very substantial assistance in showing teachers not only what they have to do but also how they can do it.

Geriatric Nursing by Kathleen Newton, R.N., M.A. 483 pages. The C. V. Mosby Company, St. Louis, Mo. 3rd ed. 1960. Price $6.50.
Reviewed by Miss Unnur Kristjansson, 122½ Garfield St., Winnipeg 10.

The author's broad purpose in attempting to present the aspects of geriatric nursing is to bring into focus areas of special need for this particular patient. An intensive description of the care of the elderly sick is not intended. Main emphasis has been placed on:

1. Understanding the amazing shift in population ratio of our senior citizens;
2. the complex environmental and social factors that contribute to illness, and/or influence the degree of recovery and rehabilitation;
3. the emotional factors that are so closely intertwined with the physical and environmental factors in the progress of a patient.

Such understanding is basic to the successful performance of the graduate or student nurse who is to contribute a humanitarian service within the community, hospital or public health agency.

The author has divided the book into three areas. The first deals primarily with the problems, emotions and social attitudes of the aged. The ideas related to health, happiness and educational programs that are developed, though briefly discussed, form a good starting point. The nurse can constructively enlarge upon them in her role as an effective citizen within her community.

The second section deals with two nonspecific factors — hygiene and nutrition — as they apply to the geriatric patient. The essential components of all nursing care are considered, such as the prevention of disabilities, health teaching, and rehabilitation as they apply to the geriatric patient.

The final section, which is devoted to clinical nursing and comprises two-thirds of the text, is disappointing. There was tremendous scope for developing and strengthening the nursing themes that were outlined in the preface. Although reference is made to these themes, they are not an integral part of the nursing care as outlined. The physical components of care, coupled with medical and surgical procedures and definitions, take

One cannot always be laughing at a man without now and then stumbling on something witty. — JANE AUSTEN

precedence. This approach prevents the author from achieving the objectives she described for comprehensive nursing care of the geriatric patient. Nursing procedures, operative procedures, medical management of specific conditions, treatments and drugs, are dealt with at some length. These may be found in any medical-surgical nursing text. It would have been more useful to point out variations in them that are necessary for geriatric patients, since the principles do not differ.

One can infer from the preface that the author believes in the values inherent in comprehensive care. However in only one chapter, "Psychiatric Nursing," does she specifically state that an attempt should be made to assign the same nurse to a given patient over a period of time, or that nursing should be individualized for the specific patient. The technical content, on the whole, is accurate and fairly up-to-date. However, there is frequent reference to the use of boracic solutions and boric-containing compounds for treatments, now largely outmoded. I question some of the dietary suggestions for the elderly, for example the liberal use of herbs and spices to stimulate the appetite.

The ideas expressed in the first two sections of this text should present a challenge to the progressive nurse who is interested not only in improving her nursing care of the geriatric patient, but also in more effective health teaching within the community. However she will have difficulty in integrating these thought-provoking ideas with the physical care of a specific geriatric patient, if she uses the third section, which on the whole is physical-care centered, as a guide.

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General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particular, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

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Public Health Nurse for generalized program in the City of Belleville. Salary $3,600 - $4,600, 4-wk. vacation, P.S.I., pension plan, car allowance or transportation provided. Apply: Dr. McColl Metcalfe, M.O.H., 266 Pinnacle Street, Belleville, Ontario.

Public Health Nurse (qualified) position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Box 1019, Bracebridge, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurse for City of London, Must have Public Health nursing degree. Full civic benefits. Salary dependent on experience & qualifications with range from $3 530 yearly. Address all correspondence to: W. J. Anthony, Personnel Director, City Hall, London, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose & throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital. London, Ontario.

Nurses (2) for United Church Mission Hospital in northern B.C. Salary: $305 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia** or Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Ave. East, **Toronto, Ontario.**

Office Nurse — In the beautiful Highlands of Haliburton, Ontario. To do general office nursing, no bookkeeping, but should be able to type, at least slowly. 31-hr. wk., 1-mo. vacation with pay, living accommodation easily available. Salary open, $240 - $300 per mo., depending on experience with increments of $10 per mo., twice yearly, all statutory holidays, every week-end off. Reply in confidence to: Dr. F. E. A. Griffiths, Box 190, Minden, Ontario.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

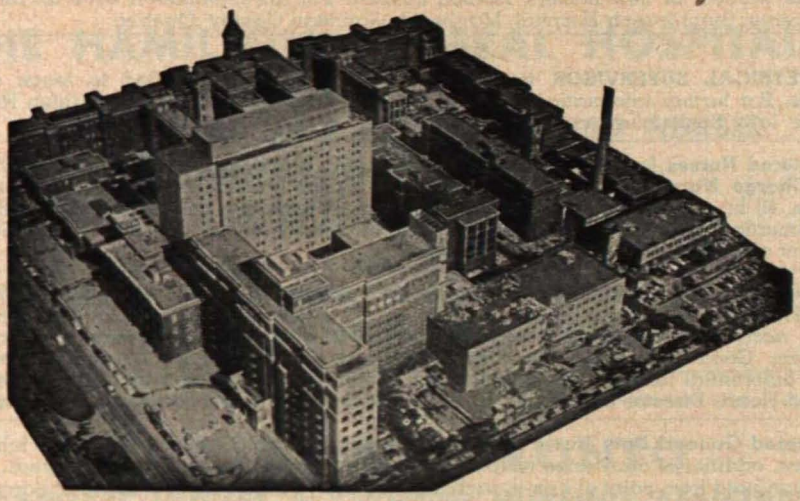
QUEBEC

Directress of Nursing. Should have some previous experience in administration of small or large hospital, & be at least partially bilingual. Salary range: $425 to $460 per mo. depending on experience & qualifications. Please address all inquiries directly to: Medical Director, Boisvert Memorial Hospital, P.O. Box. 310, Baie Comeau, Quebec.

Assistant Head Nurses: excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50-mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk., 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 60-bed General Hospital, salary $275 per mo. 5 semi-annual increases; 40-hr. wk., 4-wk. vacation. Cert. N.A. starting salary $200, 3-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.



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for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies

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TOWNSHIP OF NORTH YORK

requires

SUPERVISOR OF PUBLIC HEALTH NURSING

Duties:

Under general direction of the Director of Public Health Nursing, assist in directing and formulating policies and procedures.

In the absence of the Director, act as her Deputy.

Minimum Qualifications

A registered Nurse in the Province of Ontario with a certificate in public health nursing.

A certificate in Administration and Supervision in public health nursing.

A minimum of 3 years experience in a supervisory capacity.

This is a permanent appointment with excellent employee benefits.

The present staff establishment is as follows: Director of Public Health Nurses; 1 — Supervisor of Public Health Nurses; 3 — Assistant Supervisors of Public Health Nurses; 40 — Public Health Nurses.

Salary Range

1st year	2nd year	3rd year	4th year	5th year
$4,865.	$5,124.	$5,382.	$5,641.	$5,900.

(Starting salary dependent upon qualifications and experience)

Apply by letter giving full details as to age, qualifications and experience to the

PERSONNEL OFFICER, TOWNSHIP OF NORTH YORK, 5000 YONGE STREET, WILLOWDALE, ONTARIO.

Nurses wanted for new modern 100-bed hospital. For full information write to: Directress of Nursing, Saint Joseph Hospital, Maniwaki, Gatineau County, Quebec.

SASKATCHEWAN

OBSTETRICAL SUPERVISOR for 25-bed Obstetrical Unit. Qualified to teach student nurses. For further information apply to: Director of Nursing, Moose Jaw Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: **General Duty** $300 per mo. **Charge Nurses** $315 per mo., with semi-annual increments. Recognition for experience. 40 hr. wk., 4 wks. paid annual vacation, 10 statutory holidays, sick benefit & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses (2-immediately) for 160-bed modern hospital. Salary: $280-$355. 40-hr. wk., 21-28-day vacation, 10 statutory holidays. Good personnel policies. Comfortable living accommodation available in the city. Good orientation & in-service educational program. Good recreational facilities. Meals may be taken at the hospital cafeteria. 50 cents differential for each 8-hrs. of evening & night rotation. Apply to: Sister Anne of the Sacred Heart, Director of Nursing, Notre Dame Hospital, North Battleford, Saskatchewan.

Registered General Duty Nurse for modern company hospital. Salary $315 plus full maintenance, additional allowance for postgraduate work. $25 increase after one year. Transportation paid from point of hire in exchange for one year service. Attractive holiday benefits, group insurance, recreational facilities. Apply to: The Hospital Matron, Gunnar Mining Limited, Gunnar, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

REGISTERED NURSES (2 or 3) for **General Duty** for 80-bed modern hospital in Imperial Valley, Calif. Air conditioned hospital & attractive nurses' residence. Salary comparable to other parts of country. Please apply: Administrator, Pioneers Memorial Hospital District, Route 1, Box 70, Brawley, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses immediate openings in most departments, well equipped 90-bed General Hospital located in the heart of Northern California recreational area. Good salary & fringe benefit program. Write: Personnel Department, Mercy Hospital, Redding, California.

Pediatric Nurses: Excellent opportunity due to expansion of Pediatric Department in a 525-bed General Hospital located in the heart of California. Starting salary $370 days, $395 P.M. & nights. Liberal employment benefits. Pleasant climate. Area close to all summer & winter recreational activities. Write Personnel Office, Sutter Community Hospitals, 2820 - L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurse (immediate position on staff) for new 150-bed hospital. Immediate California registration available. Write: Director of Nursing, Little Company of Mary Hospital, Torrance, California.

Registered Nurses — Openings for General Staff Duty in all services including orthopedics, pediatrics, obstetrics, intensive therapy, rehabilitation, surgery. Challenging opportunities for personal & professional advancement. Apply: Personnel Director, Mount Zion Hospital & Medical Center, 1600 Divisadero Street, San Francisco 15, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. Area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurse Positions open on all shifts for 50-bed modern Psychiatric Hospital located near colleges, universities & in thte heart of a residential area. Salaries commensurate with experience. Personnel benefits include 2-wk. paid vacation, sick leave, paid Blue Cross, 8 paid holidays, & social security retirement. Apply: Miss Betty Remmel, R.N., The Westwood, 2112 S. Barrington Avenue, Los Angeles 25, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Registered Nurses for 200-bed General Hospital located in beautiful suburban residential area on Lake Michigan, 30-min. from Chicago. Base salary $380, differential of $20 for nights, $30 for evenings. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago. Recent completion of new building creates opportunities in all clinical services, liberal personnel benefits include free retirement program. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Operating Room Nurses for modern 200-bed General Hospital along the shores of Lake Michigan, 30-min. from Chicago. Progressive salaries and policies. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago, 6-room brand new operating suite, utilizing most current "nurse saving" methods & equipment. If you're a confirmed OR nurse you'll be right at home in our OR! If you feel you might be interested in OR (but aren't sure) **our** OR will convert you, beyond any doubt. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Nurses — The oldest hospital in Minneapolis, now located in a totally new, completely air-conditioned 306-bed building, has openings in all services. Hospital has approved internship & residency program, plus accredited school of nursing. Excellent facilities, wonderful climate, still close to your home. Starting salary in accord with contract agreement with Minnesota Nurses' Association. Tenure increases. Liberal vacation & sick leave program. For further information contact: Director of Personnel, St. Barnabas Hospital, 714 Ninth Avenue South, Minneapolis, Minnesota.

Staff Nurses present 260-bed hosp. with 120 Med-Surg. beds now under construction for completion Aug. 61. Trans. pd. 1st. class air to Albuq. & return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment". Career opportunities, largest pvt. JCAH accredited hosp. in state; near U of New Mexico — R.N. & B.S.pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds. & O.R. Salaries $315 per mo. Even., Night or O.R. with call; 6-mo. increases up to $375; Days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5-wks., annual physical exam., vacation 1-yr.-2-wks., 2-yrs.-3wks., 5-yrs.-4wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Centre, 1012 Gold. S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

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Graduate Nurses for 450-bed non-sectarian acute General Hospital wtih NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses rapid developing Texas resort & industrial center on Gulf. New six story addition opening. Contact: Personnel Director, Spohn Hospital, Corpus Christi, Texas.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & O.R. Nurses for 210-bed General Hospital, start—days $355-$395, evenings $380-$420, nights $375-$415. O.R. starts $385. University city, postgraduate study at 2 universities, 40-hr. wk., 7 holidays, vacation, sick leave benefits, free Blue Cross hospital-medical insurance & $1,000 life insurance. Retirement program, extensive Intern-Resident educational program, living quarters available. Write: Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington. 'Come to the Seattle World's Fair April 21 to October 21, 1962'.

Staff Nurses: Exchange Visitor program offers opportunities to learn & earn at large modern tuberculosis hospital in convenient suburban Cleveland, Ohio. Start at $344 per mo. with semi-annual increments. 5-day work wk., paid vacation & 6 holidays, liberal sick leave, board, room & laundry at low rate in pleasant accommodations in nurses' home. Increase your professional experience at a progressive accredited hospital in an expanding community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

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Registered Nurse as Assistant to Head Nurse O.R. postgraduate course not essential, experience necessary. Apply stating experience to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

ONTARIO

Public Health Nurses — Minimum salary $3,500, allowance for experience up to 3 yrs., car allowance, pension plan, & other benefits. Personnel policies on request. Apply to: Dr. J. M. McGarry, M.O.H., St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurses for generalized Public Health Nursing Service. Hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½ days monthly, vacation 4-wk. per yr., car allowance, salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. I. T. Loudon, M.O.H. and Director, Norfolk County Health Unit, Box 247, Simcoe, Ontario.

Registered Nurses, General Duty, min. starting rate $330 per mo., rotating shifts, 44-hr. wk., room, board & laundry. Mail first inquiry to: Dr. H. F. Mowat, Chief Surgeon, Copper Cliff Hospital, Copper Cliff, Ontario.

U.S.A.

Graduate Nurses evening & night shifts, starting at $440 per mo. California registration required. For information, write: Betty Hartwig, R.N., Los Angeles County General Hospital, P.O. Box 1311, 1200 N. State Street, Los Angeles 33, California.

Staff Nurses urgently needed on all shifts in small General Hospital with informal & congenial atmosphere. Differential for evening & night duty. Blue Cross & Blue Shield paid by hospital. Paid holidays & sick leave, & vacation. Convenient transportation, reasonable rentals in neighborhood. Apply: Director of Nurses, Forkosh Memorial Hospital, 2544 W. Montrose Avenue, Chicago 18, Illinois.

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163-bed hospital for a term of nine to twelve months, while present director is on a leave of absence to further her postgraduate studies.

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Salary commensurate with experience and qualifications.

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40 hour week - pension plan - good salaries and personnel policies.

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Candidates must be graduates from an approved school of nursing and possess current registration in a province of Canada, and a certificate in Teaching and Supervision or Nursing Service Administration.* In addition, candidates for Nurse 4 positions must possess at least five years of acceptable experience, two of which must have been at the administrative or supervisory level, while candidates for Nurse 3 positions must possess at least four years of acceptable experience, some of which have been in an administrative, teaching or supervisory capacity.

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School of Nursing

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A six month *Clinical Course* in *Operating Room Principles and Advanced Practice.*

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Complete maintenance or living-out allowance is provided for the full course.

Salary—a generous allowance for the last half of the course.

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